Kneesworth House

Quality Report

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

Ratings

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

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

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

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

Summary of findings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This service was placed in special measures on 30 July 2019. When we inspected the service again, we found that significant improvements had been made in a number of areas and the overall rating of the hospital has improved. However, we have rated other services within the hospital as inadequate in the safe domain. The service will therefore remain in special measures for a further period until we are assured that all the necessary improvements have been completed. The service will be kept under review and if needed could be escalated to urgent enforcement action. Should we feel that it is necessary, another inspection will be conducted within six months, to assess whether these improvements have been made.

Professor Edward Baker
Chief Inspector of Hospitals

Overall summary

We rated Kneesworth House as **requires improvement** because:

- The hospital did not provide consistently safe care. Emergency equipment and physical health monitoring equipment were not always present, appropriately maintained and easily accessible. The hospital did not consistently manage medicines safely. Staff did not consistently monitor the side effects of medicines or complete care plans for monitoring patients prescribed clozapine.
- Patient bedrooms were not en-suite and patients had to share toilets, showers and bathroom facilities. Ward layouts were not always helpful in promoting personalised care planning for patients. The environment on the rehabilitation wards was poor. On Nightingale ward, staff secluded patients in a decommissioned seclusion room which contained potential safety hazards for patients.
- The acute ward, psychiatric intensive care unit and some rehabilitation wards some rehabilitation wards placed blanket restrictions on patients without assessing and documenting individual risk. These included not having access to keys and mobile phone chargers and restrictions to going outside.
- Managers and staff did not complete all episodes of seclusion in line with Mental Health Act Code of Practice on rehabilitation and forensic wards and did not complete all seclusion paperwork in line with Mental Health Act Code of Practice.
- Managers provided training data during the inspection. This showed that mandatory training on the rehabilitation wards, was below 75% in some key areas, such as fire safety, managing challenging behaviour, rapid tranquilisation, safeguarding children and adults and clinical risk assessments. Staff on the rehabilitation wards did not have access to additional rehabilitation-focused training. Not all staff were up to date with Mental Health Act and Mental Capacity Act training. Managers had not ensured action was taken to address this.
- The clinical records system was slow. Staff could not always locate records when they needed to. In the rehabilitation services, meeting minutes from lessons learned discussions were sparse and poorly recorded. Staff across all wards were unable to give examples of recent lessons learned. Governance systems did not always ensure that essential learning and information passed between the hospital's senior management team and the nursing team.
- In the rehabilitation service, staff did not fully assess the physical health needs of patients on admission and did not routinely monitor their health or identify when their condition was deteriorating, including the monitoring of patients on Clozapine.
- Care plans on the forensic wards did not reflect the patient voice. Community meetings in the forensic service did not document outcomes of concerns raised by patients.

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to

Summary of findings

keep patients safe from avoidable harm. The provider had addressed the issues found at the focused inspection in June 2019. The environments on Wimpole ward and the forensic/secure wards had improved and staffing numbers had increased on the forensic/secure wards.

- Staff assessed and managed risk on admission, and reviewed this regularly, including after incidents. Staff followed best practice in anticipating, de-escalating and managing behaviours that challenged and used restraint and seclusion only after attempts at de-escalation had failed. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- On the acute ward and psychiatric intensive care unit, the service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications patients' physical health on these wards.
- Staff assessed the physical and mental health of all patients on admission. They developed care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were holistic and recovery-oriented. Care plans in the rehabilitation and acute services were personalised.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance. Ward teams included or had access to the full range of specialists required to meet the needs of patients. Staff from different disciplines worked together as a team and held daily multidisciplinary meetings to benefit patients, attended by members of the senior management team, doctors and nursing staff.
- Managers made sure staff had a range of skills needed to provide high quality care. They provided an induction programme for new staff, supported staff with appraisals and supervision, identified training needs and gave staff the time and opportunity to develop their skills and knowledge.
- Most staff treated patients with compassion and kindness and respected patients' privacy and dignity. Staff gave patients help, emotional support and advice when they needed it. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessments. They had a good understanding of patients' needs, supported them to understand and manage their treatment and ensured they had easy access to independent advocates. Staff informed and involved families and carers appropriately. Staff invited carers to multidisciplinary meetings and monthly ward reviews.
- Managers were visible in the service and approachable for patients and staff. Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Staff felt able to raise concerns without fear of retribution.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good	Bourn ward Wimpole ward - psychiatric intensive care unit
Forensic inpatient or secure wards	Requires improvement	Clopton ward - medium secure unit Ermine ward - medium secure unit Orwell ward - low secure unit
Long stay or rehabilitation mental health wards for working-age adults	Requires improvement	Bungalows 63, 65, 67 & 69 Fairview ward Swift House Nightingale ward Wortham ward

Summary of findings

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Requires improvement

Kneesworth House

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Long stay or rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Kneesworth House

Kneesworth House is part of the Priory Group of companies. It provides inpatient care for people with acute mental health problems, locked and open rehabilitation services, including some patients with a learning disability, and medium and low secure forensic services for people with enduring mental health problems, including some patients with a learning disability.

The Care Quality Commission last completed a comprehensive inspection of this location between 19 March and 4 April 2019. Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. Requirement notices were issues under the following regulations:

- Regulation 9 – Person-centred care
- Regulation 10 – Dignity and respect
- Regulation 12 – Safe care and treatment
- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 15 – Premises and equipment
- Regulation 17 – Good governance
- Regulation 18 – Staffing

The overall rating for this location was inadequate, with inadequate in the safe, caring and well-led domains and good for effective and responsive, and the provider was placed in special measures. The provider submitted action plans in relation to the breaches identified and had addressed some of the concerns identified at that inspection.

The Care Quality Commission completed a focused inspection in June 2019 of the forensic wards and the newly opened psychiatric intensive care unit. We took enforcement action and imposed a number of conditions on the provider. We have undertaken two further inspections, on 1 August 2019 and 3, 22 and 23 October 2019 to make sure that improvements had been made. We found that the provider made improvements in relation to all the conditions imposed by the CQC.

The service is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

The hospital had 136 beds. Since the inspection in March 2019, the provider had closed Icknield ward, a 16-bed medium secure service for men with a learning disability, in June 2019. They had also opened Wimpole ward, a 12-bed psychiatric intensive care unit for women, in April 2019.

We inspected the following core services:

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

- Bourn - 12 bed service for women
- Wimpole ward – 12 bed psychiatric intensive care unit for women

Forensic inpatient/secure wards

- Clopton - 15 bed medium secure service for men with a personality disorder
- Ermine - 19 bed medium secure service for men with a mental illness
- Orwell - 18 bed low secure service for men with a mental illness

Long stay/rehabilitation wards for working age adults

Open settings:

- Bungalow 63 - four bed service for men with a mental illness
- Bungalow 65 - four bed service for women with a mental illness
- Bungalow 67 - four bed service for men with a mental illness. At the time of the inspection, this Bungalow had been adapted to accommodate one patient.
- Bungalow 69 - four bed service for men with a mental illness
- Swift House - four bed service for men with a mental illness/learning disability

Summary of this inspection

Locked settings:

- Nightingale ward - 17 bed service for men with a mental illness.
- Wortham ward - 17 bed service for men with a mental illness.
- Fairview - six bed service for women with a mental illness.

Our inspection team

The team that inspected the service comprised six CQC inspectors, two CQC inspection managers, one Mental Health Act reviewer and a variety of specialists: four nurses, one consultant psychiatrist, one occupational therapist and three experts by experience.

Why we carried out this inspection

We inspected this service to see if improvements had been made following the decision to place the service in special measures after the previous comprehensive inspection in March and April 2019.

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 the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all twelve wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with 35 patients and seven family members of patients who were using the service;
- spoke with the registered manager, company directors and managers or acting managers for each of the wards;
- spoke with 52 other staff members; including doctors, nurses, occupational therapists, psychologists and social workers;
- looked at 35 care and treatment records of patients;
- looked at 23 seclusion records;
- looked at 61 prescription charts, carried out a specific check of the medication management on seven wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 35 patients and seven carers or family members of patients. Patients we spoke with told us that most staff were kind, caring and respectful and treated them well. They told us staff listened to them and considered their views on their care during review meetings and had their best interests at heart. Patients

Summary of this inspection

said they felt comfortable to raise concerns about abuse and unfair treatment and said staff were responsive when they did. Patients we spoke with on the acute ward and psychiatric intensive care unit told us that they were happy with their care and treatment, including physical healthcare access when needed. Three patients on the forensic/secure wards stated they had a good rapport with doctors at the hospital.

However, two patients on the forensic/secure wards told us there were still some staff who were uncaring and rude on occasions and some agency staff did not speak English. One patient we spoke with on the forensic/secure wards, told us he was at the hospital for one month before being allocated a named nurse.

Patients told us staff had shown them around when they were admitted to the ward. However, on the acute ward, two patients told us that staff had not made their bed when they arrived and that they gave them bedding to make their own bed. Patients we spoke with on the acute ward and psychiatric intensive care ward told us they felt physically safe on the ward. However, they told they would have liked to have a key to their bedroom to keep their possessions secure. They told us it could be difficult to get staff attention at times from the nursing office.

On the forensic/secure wards, patients told us the quality of the food was good. However, on the rehabilitation wards, some patients said there was not always a vegan option presented even though there were vegan patients on the wards.

Family members we spoke with felt that staff were always kind and respectful. Most family members we spoke with said they had been given the chance to feed back to the service about their relative's care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- The hospital did not provide consistently safe care. Emergency equipment and physical health monitoring equipment were not always present or appropriately maintained on all forensic and rehabilitation wards. This included timely access to equipment during an incident of self-harm on some rehabilitation wards.
- The hospital did not always manage medicines safely. Systems and processes for the storage of medicines were not sufficient to assure us only appropriately trained and qualified staff had access to medicines on Orwell ward. We were not assured all emergency medicines were accessible on the forensic wards when required in the event of an emergency. Staff did not consistently monitor the side effects of medicines on the rehabilitation wards or have a clear process to safely prescribe medicines or manage patients' own medicines. The provider had not completed care plans for monitoring patients prescribed clozapine.
- The hospital placed blanket restrictions on patients without assessing and documenting individual risk. On Bourn and Wimpole wards, patients did not have keys to their bedrooms or access to mobile phone chargers. On some rehabilitation wards, staff restricted access to the outside areas and bedrooms.
- Managers and staff did not complete all episodes of seclusion in line with Mental Health Act Code of Practice on rehabilitation and forensic wards and did not complete all seclusion paperwork in line with Mental Health Act Code of Practice.
- Managers provided training data during the inspection. This showed that mandatory training on the rehabilitation wards, was below 75% in some key areas, such as fire safety, managing challenging behaviour, rapid tranquilisation, safeguarding children and adults and clinical risk assessments. Staff on the rehabilitation wards did not have access to additional rehabilitation-focused training. Not all staff were up to date with Mental Health Act and Mental Capacity Act training. Managers had not ensured action was taken to address this.
- In the rehabilitation services, meeting minutes from lessons learned discussions were sparse and poorly recorded.
- The environment on the rehabilitation wards was poor. Some of the rehabilitation wards did not have sufficient room for staff to

Summary of this inspection

restrain patients safely when needed. The provider had not maintained all areas to a high enough standard to ensure staff could maintain cleanliness. On Nightingale ward, staff secluded patients in a decommissioned seclusion room which contained potential safety hazards for patients.

- In the forensic and rehabilitation services, the clinical records system was slow. Staff could not always locate records when they needed to.

However:

- Wards in the acute and forensic/secure services were clean, well equipped, well furnished, well maintained and fit for purpose. The provider had addressed the environmental issues on Wimpole ward and the forensic wards, identified at the focused inspection in June 2019.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risk on admission, and reviewed this regularly, including after any incident. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour and used restraint and seclusion only after attempts at de-escalation had failed. Staff on acute and forensic/secure wards participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff on the forensic, acute ward and psychiatric intensive care unit had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had access to clinical information and stored records securely.
- On the acute ward and psychiatric intensive care unit, the service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health on these wards.
- Staff recognised incidents and reported them appropriately. On the acute ward and psychiatric intensive care unit, managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Summary of this inspection

Are services effective?

Requires improvement 

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

- In the rehabilitation service, staff had not fully assessed the e physical health needs of 10% of patients on admission and did not consistently monitor patients' health or identify when their condition was deteriorating, including the monitoring of patients on Clozapine.
- Staff on the rehabilitation wards did not have access to additional rehabilitation focused training.
- Data provided from ward managers highlighted that only 72% of staff on the rehabilitation wards were up to date with Mental Health Act and 66% of staff were up to date with Mental Capacity Act training.
- Management supervision in the rehabilitation service was not consistent and managers did not always set actions or carry them over.

However:

- Staff in the acute and forensic services assessed the physical health of all patients on or soon after admission and reviewed this regularly. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were, holistic and recovery-orientated and showed detailed future planning. Staff regularly reviewed and updated care plans when patients' needs changed.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme, identified training needs and gave staff the time and opportunity to develop their skills and knowledge.
- Staff from different disciplines worked together as a team and held regular multidisciplinary meetings to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other teams within the organisation and with relevant services outside the organisation. The provider held daily meetings attended by members of the senior management team, doctors and nursing staff.

Summary of this inspection

- Staff used recognised rating scales to assess to record severity and outcomes. Most wards also participated in clinical audit, benchmarking and quality improvement initiatives.
- Managers dealt with poor staff performance promptly and effectively.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Staff gave patients help, emotional support and advice when they needed it. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff had a good understanding of patients' needs and supported them to understand and manage their treatment.
- Staff informed and involved families and carers appropriately. Staff sought consent from the patient to involve family members and respected their wishes if they refused. Most records we reviewed showed evidence of family involvement in the risk assessment and the care plan.
- Staff invited carers to attend multidisciplinary meetings where appropriate. Staff invited family members to the monthly ward reviews, where appropriate.

However:

- Care plans on the forensic wards did not consistently reflect the patient voice.
- Patients on the acute ward and psychiatric intensive care unit said staff were sometimes busy and took too long to give them help when they needed it. Patients on the forensic/secure wards said some agency staff didn't speak English.

Are services responsive?

Good

We rated responsive as **good** because:

- The ward environments in the acute award and psychiatric intensive care unit enabled staff to ensure patients' treatment, privacy and dignity. The provider had rectified the issues on

Summary of this inspection

Wimpole ward found at the focused inspection on 23-25 June 2019. There were rooms for meeting visitors. Patients could make phone calls in private. All patients had access to personal mobile and ward telephones.

- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service actively engaged with commissioners to move people where appropriate. The wards accepted patients from out of area. Patients were not moved between wards unless this was for their benefit. When patients went on leave there was always a bed available when they returned. Patients were discharged to suitable placements nearer home when possible. Discharge was rarely delayed for other than clinical reasons.
- The service met the needs of all patients who used the service – including most with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Patient bedrooms were not en-suite and patients had to share toilets, showers and bathroom facilities. Ward layouts were not always helpful in promoting personalised care planning for patients.
- Although patients could order vegan meals, patients we spoke with on the rehabilitation wards told us vegan options were not consistently offered on menus.
- On acute, psychiatric intensive care unit, forensic and some rehabilitation wards the hospital did not cater well for patients with significant mobility issues, including wheelchair users due to the ward layouts.
- The provider had not always kept patients' possessions safe on psychiatric intensive care unit and the acute and forensic wards.
- On forensic wards, the community meeting minutes did not record feedback or actions taken as a result of patients' concerns.

Are services well-led?

Requires improvement

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

- The senior leadership team had not fully addressed all previous concerns raised in the forensic service. The provider had not

ensured that seclusion practises were in line with the Mental Health Act Code of Practice or that clinic rooms were well organised, and that equipment was sufficient and in good working order.

- Six-weekly training and team meetings minutes did not reflect discussions about lessons learnt. Therefore, we could not be assured that essential information was being shared at this forum to good effect. In the rehabilitation service, minutes for these meetings were sparse and poorly recorded. Community meetings in the forensic service did not document outcomes of concerns raised by patients.
- In the forensic wards, managers had to cover for staff on occasions, which impacted on their ability to manage their team effectively.
- In the rehabilitation service, the provider's governance systems were not sufficiently robust to ensure that essential learning and information passed between the hospital's senior management team and the rehabilitation nursing team. Staff across all wards were unable to give examples of recent lessons learned.
- In the rehabilitation service, ward managers were not aware of shortfalls in staff training numbers and had therefore not taken action to remedy this. Senior managers had calculated overall training rates for the hospital but had failed to identify that the rehabilitation wards had lower compliance rates than their targets.

However:

- Managers had taken a measured approach towards admitting new patients on the psychiatric intensive care unit and had paused admissions to address the mix of patients on the ward.
- Managers were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Patients and carers had opportunities to give feedback on the service they received. Managers and staff responded to concerns raised by patients.
- Governance processes operated effectively at ward level and performance and risks were managed well.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff received training in the Mental Health Act with 87% of staff having completed training. Staff had a good understanding of the Mental Health Act and the guiding principles. However, in the rehabilitation service, managers provided training data during the inspection which showed compliance for this training in the rehabilitation service was only 72%.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff knew who their Mental Health Act administrator was and how to get support when they needed it.

Staff made patients aware of their rights under the Mental Health Act. We saw clear evidence of staff reading patients their rights and recording this appropriately on the electronic notes system.

Patients had easy access to specialist Mental Health Act advocacy services which staff advertised using posters on the ward. Staff automatically referred patients who lacked capacity to the service. Advocacy representatives attended community meetings held weekly for patients on the wards.

Staff made sure patients could take Section 17 leave (permission to leave the hospital) when agreed with the responsible clinician and/or with the Ministry of Justice. Staff devised appropriate section 117 aftercare plans for patients when planning for their discharge. The provider rearranged this leave when it had been cancelled due to short staffing.

Where patients lacked capacity, staff sought approval from a Second Opinion Appointed Doctor (SOAD) when detaining patients under the Mental Health Act and kept records of this paperwork with the patient's notes.

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

The service displayed notices to tell informal patients that they could leave the ward freely.

The Mental Health Act administrator for the hospital conducted audits to ensure that the Mental Health Act was being applied correctly and discussed the findings with staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received, and were up to date, with training in the Mental Capacity Act. Staff compliance across the hospital was 91%. However, in the rehabilitation service, managers provided training data during the inspection which showed compliance for this training in the rehabilitation service was only 66%. Staff had a good understanding of the five principles. We saw these principles displayed in locked notice boards on the wards.

Staff supported patients with capacity to make their own decisions and recognised their right to make an unwise decision. Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to do so. Staff assessed and clearly recorded patients' capacity to make specific decisions and revisited this regularly. Where patients did not have capacity to make their own decision, staff made appropriate best interest decisions, sought the views of those closest to the patient and considered the individual's wishes, culture and history.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it and were aware of where to get additional advice when needed.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement

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

Good

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe and clean environment

Bourn and Wimpole wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff had completed an environmental risk assessment including potential ligature anchor points and where staff could not remove ligature risk points, they mitigated risks through staff observations. Managers had completed a photo guide to high risk areas displayed in the staff office for staff to easily note the risk areas and mitigating guidance.

The wards had blind spots where staff could not observe patients at all times. However, mirrors and closed-circuit television had been installed to improve observation. Staff carried personal alarms to call for assistance if required, and patients had access to call bells to raise help.

The wards complied with same-sex accommodation guidance as both wards only admitted female patients.

Wimpole ward had had some refurbishment since the focused inspection in June 2019 which identified issues in relation to cleanliness, infection control and the quality of the ward environments. The provider had addressed the environmental issues we identified, and cleanliness levels had significantly improved. Both wards were visibly clean in all areas and had daily housekeeping visits to complete a full clean of all areas. The furniture was well maintained and comfortable. However, managers identified that dining room chairs on Wimpole ward were not particularly sturdy and weighty, given the service had a number of patients with behaviour that challenged.

Staff adhered to infection control principles with handwashing facilities and anti-bacterial gel was available throughout the ward and in clinic rooms.

The clinic rooms on both wards were fully equipped and equipment was clean and checked regularly. Emergency drugs were available and stock medicines were checked and audited weekly. Staff monitored room and fridge temperatures daily and all medications were labelled and in date.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The provider had calculated the number of nurses and healthcare workers required and reviewed this when required; for example, the provider increased the overnight shift requirement on Bourn ward from one to two qualified nurses. We saw that the number of staff on duty matched the number required on all shifts and that additional staff were deployed when patients required one to one observation. There were only three patients on Wimpole ward so staffing levels were high.

The provider reported that the service had 28 substantive nursing staff, 23 on Wimpole ward and 12 on Bourn ward. The vacancy rate was 13% on Wimpole ward and 57% on Bourn ward. On Bourn ward four of the vacancies were covered by contracted locum staff who had received an induction and were familiar with the ward environment. Nine members of staff had left the service in the 12 months

prior to inspection, five on Wimpole ward and four on Bourn ward. Between 1 July 2019 and 30 September 2019, 379 shifts were filled by bank and agency staff and five shifts were not covered. Bank and agency usage was highest on Bourn with 198 shifts and the lowest on Wimpole with 150 shifts. Staff sickness across the service during this period was under 4%.

Wimpole ward had only three patients at the time of the inspection. In June 2019, the CQC took enforcement action against the provider, preventing further admissions and later capping ward numbers to a maximum of three patients. This had been lifted in November 2019 to allow a maximum of eight patients. The ward had recently started to increase admissions again but had encountered problems with the mix of patients which led to an increase in incidents and difficulties in maintaining patient safety. As a result, they had ceased taking further admissions until they could resolve this issue and the ward was settled. Staffing numbers on Wimpole ward were therefore high due to the number of patients. However, it was not clear what staffing numbers would be as patient numbers increased. The Priory's 'staffing ladders', calculated how many staff should be allocated to the ward, taking into account patient numbers and one to one observations. Managers we spoke with told us they had reviewed these and indicated that the ward would be staffed in line with patient risk.

Staff took breaks throughout their shift.

Staffing levels were reviewed each morning at the daily managers meetings and the hospital employed a 'floating' staff member who could cover in the event of a scheduled staff member calling in absent from work due to sickness. Managers could deploy bank and agency staff to cover staff absence and the provider used long term contracted agency staff so that they were familiar with the wards and patient group. Bank and agency staff received an induction on to the ward and accessed the same mandatory training sessions as permanent staff.

Each ward had an allocated staff member to respond to any alarm call so that there were enough staff to safely carry out any physical interventions. Staff shortages rarely resulted in staff cancelling escorted leave or ward activities, however patients told us that due to the absence of the activities co-ordinator, there had been a short delay in alternative activities being organised.

The wards had sufficient medical cover with a consultant psychiatrist and ward doctor in post on both wards, and access to medical cover through the duty doctor overnight. There was an on-call doctor who lived on site during the out of hours period.

Staff had received and were up to date with appropriate mandatory training. The provider set 18 training sessions as mandatory training and 87% of staff on Bourn ward and 93% of staff on Wimpole ward were up to date with all training sessions. The highest compliance percentage was for the prevention and management of violence and aggression training with 100% of eligible staff having completed this session.

Assessing and managing risk to patients and staff

In June 2019, when we undertook a focused inspection of Wimpole ward, we had serious concerns about the quality of risk assessments, risk formulations and risk management plans. Staff had not always completed risk assessments on admission or updated them consistently after incidents. Staff had not completed risk formulation or risk management plans for some patients and did not update risk assessments for one patient following 14 further incidents, including self-harm and violence to staff. Care plans contained some information about risk and details of behaviours that challenged, but there was no risk formulation or plan to manage them safely. Conditions were imposed on the provider by the Care Quality Commission in relation to these concerns. Two further focused inspections, in August 2019 and October 2019, showed the provider had made significant improvements. On this inspection, there were three patients on Wimpole ward. Staff completed a risk assessment for every patient on admission on both wards and updated these regularly, including after any incident. Risk assessments were thorough and of good quality. However, seclusion care plans lacked detail about how staff would manage risks in seclusion. Due to low patient numbers, we were unable to assess how Wimpole ward managed patient risk when patient numbers increased.

We reviewed eight care records and saw that staff used recognised risk assessment tools to assess all patients on admission. These were updated a minimum of once per week but as often as daily for patients with changing presentation of risk.

Staff identified changing risk levels and amended observation levels and interaction with patients in response. Staff followed provider policy on the use of observation and searching, and observation levels were discussed with the multidisciplinary team.

Staff imposed some blanket restrictions on patients. We spoke with six patients across both wards who all told us that they did not have their own bedroom key or access to a mobile phone charger. Staff told us that this was not a blanket restriction and was discussed and risk assessed as part of multidisciplinary reviews. However, we did not see any discussion noted in the eight care records we reviewed that demonstrated risks were individually assessed.

Wards had clear signs on external doors reminding informal patients that they could leave at will and patients we spoke with were all aware of this.

Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme and had completed safe wards training to reduce conflict and aid de-escalation.

Wimpole ward recorded 83 incidents of restraint in the six months prior to inspection involving 15 patients, and three incidents of seclusion. However, during this period, the number of patients was low due to the limit on admissions. Bourn ward recorded 79 incidents of restraint in the previous six months involving 16 patients, and seven incidents of seclusion. None of the restraints across the wards involved prone restraint or ended in rapid tranquilisation.

Bourn ward did not have a seclusion room as the provider had decommissioned this in 2018. When staff needed to seclude patients, they used an observation room with two staff members present at all times. Patients secluded in the observation room could access bathroom facilities across the corridor with a staff escort. Staff could also use the seclusion rooms on two other wards if needed. However, these wards were not easy to access when patients were distressed.

Wimpole ward's seclusion room was temporarily out of use at the time of inspection due to damage of the closed-circuit television monitor cabinet, so staff used a seclusion room on another ward. Otherwise, the seclusion room on Wimpole ward met the expected requirements with an en-suite bathroom facility, external window blinds and a communication system in place. At the most recent focused inspection in October 2019, the provider had made some structural changes to the seclusion room to address concerns about risk issues and the overall quality of the environment. On 3 October, the room was not in service. However, when we visited on 22-23 October 2019, maintenance staff had completed the work, making significant improvements to the room.

We reviewed six seclusion records and found that risk assessment and care plans were completed in all cases, however these did not meet the recommendations of the Mental Health Act Code of Practice as they were not specific about how risks were managed, or what strategies were used for de-escalation and engaging with patients.

We saw that patients in seclusion were offered food and drinks at regular intervals and on request, including a patient having a takeaway. Patients were given extra blankets, pillows and clothing if requested and patients who were in seclusion for prolonged periods, including overnight, had changes of clothes and hygiene needs met. Patients were able to make phone calls, for example to family or solicitors.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff on both wards had received Safeguarding Adults and Safeguarding Children training, 93% of staff on Bourn ward and 94% on Wimpole ward had completed the training.

Staff we spoke with knew how to identify when someone was at risk of harm. Staff knew how to raise a safeguarding referral and could give examples of when they had done this.

Staff were aware of the provider policy on equality and how to prevent harassment or discrimination of any patient with protected characteristics.

Staff access to essential information

The provider used an electronic patient records system that was available to all staff, including guest logins for agency staff so that all staff had easy access to patient clinical information. There were enough computers for staff to update records easily and quickly.

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

Good

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

We reviewed nine medication records and saw that staff prescribed and administered medication safely and used the 'National Early Warning Score 2' to monitor the effects of medication on patients' health.

The provider contracted a pharmacy to complete weekly audits of medicines management including prescriptions. Managers and medical staff had access to a dashboard that provided up-to-date information on prescriptions and medicines administration.

Track record on safety

Wimpole ward had recorded one serious incident in the past year, in relation to staff taking keys from the ward when responding to a medical emergency. Bourn ward had not recorded any serious incidents in the past year.

When we undertook a focused inspection on 23-25 June 2019, we judged that the ward was not safe. We found issues relating to the environment, risk assessments and staffing. Incidents were frequent, dangerous and were not well managed. Between 1 May and 25 June, there were 359 incidents reported on the ward. The majority of these were reports of patients attacking other patients, some involving up to six patients, hair pulling, spitting, kicking and punching in the face. Conditions were imposed on the provider by the Care Quality Commission in relation to these concerns including a ban on new admissions. Since the inspection in June 2019, Patient numbers had reduced, incident numbers had decreased, and staff managed these incidents more effectively. At this inspection, we saw that staff managed patients safely, although patient numbers were low. However, we were unable to assess, at the time of inspection, how the ward operated with higher patient numbers.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The provider used an electronic incident reporting system and had a policy on incident reporting and investigation. Staff we spoke with knew what incidents to report and how to report them. We reviewed the incident reports for both wards for the last six months and saw that incidents were investigated in line with policy and the outcomes of investigations were fed back to staff and patients.

After increasing patient numbers in November and December 2019, Wimpole ward experienced a period of increased incidents of violence and aggression between patients. As a result, managers had decided to reduce the number of patients on the ward and paused admissions until the ward was more stable environment. Managers told us that the referral and admissions process had not been robust enough to ensure that the patient mix on the ward was safe and that patients did not have prior incidents between them at other services. Managers planned to make the admissions process more robust and increased staff training, including safe wards and personality disorder training to increase safety on the ward.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. We reviewed eight care records and saw that staff completed a comprehensive assessment of physical and mental health on admission to the wards.

Staff developed recovery focussed, personalised care plans with patients and reviewed these regularly at multidisciplinary meetings.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national

guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. We reviewed eight care records. Interventions were delivered in line with National Institute for Health and Care Excellence guidelines, such as psychology-led emotional management sessions, mindfulness sessions, dialectical behavioural therapy informed interventions. Staff supported patients to participate in life skills activities such as cooking.

The provider employed three physical health nurses across the service to monitor and treat any physical health concerns, with access to local GPs if required. These nurses covered the whole hospital site for seven days a week. However, when we visited on 22 January 2020, two of these staff were off work and it was uncertain when they would return.

Staff used recognised rating scales including Health of the Nation Outcome Scales to assess and monitor outcomes for patients.

Staff used technology to support patients' physical health, including a service for electrocardiogram tests to be read and monitored remotely for faster results. Staff participated in clinical audit.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The teams included a consultant psychiatrist, specialist doctor, psychologist, occupational therapist, nurses and support workers. Teams had access to a dietician.

Managers ensured that staff received the necessary training for their role and staff had completed training in safe wards, working with female patients, personality disorders and dialectical behavioural therapy. Staff had also completed additional sessions on risk assessment and care planning as a result of the findings of the last inspection.

Managers provided an induction course to newly employed staff.

Managers provided staff with supervision in line with provider policy, with 92% of staff up to date with supervision. Staff also participated in weekly reflective practice group sessions led by the psychologist. Managers conducted an annual appraisal of each member of staff's work performance and 96% of staff had received an appraisal in the last year. Managers ensured that staff had access to regular team meetings. We saw that managers dealt with poor staff performance effectively.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held weekly multidisciplinary meetings and handover meetings at the start of each shift where relevant information about patients was discussed. Staff worked closely with other teams within the service and external organisations such as local authorities and commissioners.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff explained patients' rights to them.

Staff received training in the Mental Health Act with 87% of staff completing training. Staff had a good understanding of the Mental Health Act and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their mental health act administrator was.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. This was accessible to staff on the shared drive on the electronic system.

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

Good

Patients had easy access to information about independent mental health advocacy. Staff explained to patients their rights under the Mental Health Act in a way that they could understand and there were clear records to support this.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted.

Staff requested an opinion from a second opinion appointed doctor when necessary. Staff stored copies of patients' detention papers and associated records correctly on the electronic system and they were available to all staff that needed access to them. The service displayed notices on ward doors to tell informal patients that they could leave the ward freely. Staff completed regular audits to ensure that the Mental Health Act was being applied correctly.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act and assessed and recorded capacity clearly for patients who might lack capacity.

Staff had completed training with 83% compliance for Mental Capacity Act training and had a good understanding of the principles of the Mental Capacity Act.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it and were aware of where to get additional advice when needed.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to do so.

Staff assessed and recorded capacity to consent appropriately. This was on a decision-specific basis with regard to significant decisions. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with six patients across both wards who told us that staff were generally caring and supportive, however patients said that they thought staff members took too long to answer when patients knocked on the office door and that there were occasions when staff were busy and took too long to give them help when they needed it. Patients told us they felt frustrated that they could not have a key to their bedroom and three patients reported having items stolen from their bedrooms. Staff supported patients with this.

Staff had a good understanding of patients' needs and supported them to understand and manage their treatment. Staff supported patients to access additional services when required, including physical health services.

Staff could raise concerns about disrespectful, discriminatory or abusive behaviour and language towards patients and we saw that this had been investigated when reported.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

We reviewed eight care records and saw that patients were involved in their care plans and were offered a copy of the care plan. Patients participated in multidisciplinary reviews unless they declined to attend.

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

Good

Staff provided patients with an admission information pack on arrival to the ward and gave a tour of the ward. However, two patients told us that on their arrival their bed was not made, and they were given bedding to make their own bed.

Staff held weekly community meetings where patients could give feedback and raise any concerns about the wards. We saw that issues raised in community meetings were put right as quickly as possible. The provider completed a survey of patient satisfaction twice a year and reviewed the results at the clinical governance meeting.

The service contracted two independent advocacy services for patients to speak to about their treatment or rights under the Mental Health Act.

Staff informed and involved families and carers appropriately. Families and carers were invited to attend multidisciplinary meetings where patients consented and could attend in person or via telephone conferencing.

Where patients consented staff could call families and carers to update them of any changes in treatment or circumstances. However, one carer told us that they had not been contacted by staff after their family member was assaulted by another patient.

The provider held an annual support day for families and carers to attend.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

Bourn ward reported 90% bed occupancy over the past six months and Wimpole ward reported 37% bed occupancy over the past six months due to the restriction of admissions.

The provider had not fully addressed the issue of the mix of patients on Wimpole ward. When we visited in June 2019, we found that there were problems with the admission process for this ward, leading to difficulties in managing the patients on the ward. This included high levels of incidents and safeguarding referrals, due to patients attacking other patients. In June 2019 the Care Quality Commission imposed a ban on admissions; subsequently, admissions were limited to three patients until November 2019. Patient numbers had risen since then, but managers had exhibited more caution when planning future admissions. Managers we spoke with told us that, when similar incidents occurred due to the mix of patients on the ward, they decided to halt admissions until further work had been done to address this.

The service had clear criteria for accepting patients on to the wards and did not accept anyone whose physical health needs could not be met, such as anyone requiring detoxification from drugs or alcohol.

Staff planned patient's discharge from the wards and had effective liaison with care co-ordinators. Staff supported patients during transfers between services.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with a hand basin for washing. However, rooms were not en-suite and patients had to share toilet, bathroom and shower facilities.

Patients could personalise their bedrooms and had access to their own mobile telephones unless risk assessed otherwise, and both wards had a telephone in a quiet, private room. Wards had quiet rooms available for patients to use at any time.

Patients had access to outside space, with Wimpole ward having direct access to a garden area and Bourn ward having a garden area downstairs from the first-floor ward which patients could access once staff unlocked the ward door.

Patients we spoke with said the food was of good quality and they could make hot drinks and snacks at any time. Patients had a variety of choices for meals including healthy options and fruit was available in the dining room for patients to help themselves. Patients had the option of a takeaway once per week.

Patients' engagement with the wider community

Staff supported patients to meet to maintain contact with families and friends either through telephone and internet contact or visiting the wards.

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

Good

Meeting the needs of all people who use the service

The service met the needs of all patients who used the service, including those with a protected characteristic as identified by the Equality Act 2010. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service was not accessible to all patients including those with restricted mobility and wheelchair users. Wimpole ward was on the ground floor. However, after 5pm and at weekends, the ward used a different access point to enter and exit the ward which meant patients had to go upstairs then down again to access reception. The hospital did not have a lift available to patients. Managers considered these issues when accepting admissions. Bourn ward was based on the first floor so was not able to accept anyone with reduced mobility or wheelchair users, and this was clearly defined in the referral criteria.

Information about services, including advocacy, was displayed clearly on noticeboards on both wards.

The service had access to signers and translators for any patients whose first language was not English.

Staff offered patients a range of culturally appropriate food including Kosher, Halal and vegetarian options. Patients could request vegan food when needed, although menus did not consistently contain vegan options. Staff provided access to spiritual support with visiting Christian and Muslim religious leaders, and access to spiritual support for other faiths available when required.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

In the past year Wimpole ward had received four complaints with two complaints upheld and one partially upheld. Bourn ward had received 14 complaints with one upheld and two partially upheld.

Staff provided information on how to make a complaint in the patient information leaflet and on notice boards on the wards. Patients we spoke with knew how to make a complaint.

The provider had a formal complaints system and senior managers reviewed complaints to monitor trends and outcomes, and managers fed back to staff in the morning meeting. We saw examples of how staff had acted as a result of complaint outcomes, including giving visitors alarms to call for assistance if required.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

Since the focused inspection in June 2019, the provider had increased training on clinical risk formulations and risk assessments for staff on both wards.

Leaders were visible in the service and approachable for patients and staff. We were told that senior managers visited the ward much more regularly and staff felt more confident and optimistic about the future. Staff told us they felt more valued and listened to.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider values were displayed on the wards and staff understood how to apply the values to their day to day work. They were also permanently displayed on the home intranet page of the hospital for all staff. The hospital also highlighted the seven C's of care, compassion, competence, communication, courage, commitment and consistency.

Culture

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of

retribution and were aware of the provider's confidential whistleblowing hotline. Staff we spoke with were aware of how to raise any concerns and felt confident that any concerns raised would be dealt with appropriately.

The provider offered career progression opportunities for all staff and four staff members were in the process of training as nursing associates at the time of the inspection. Nursing staff also had the opportunity to access leadership training to progress in their careers.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The service's staff sickness rate across both wards was under 4%.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

The provider did not have one governance dashboard for managers to have an overview of performance. Managers accessed the information through different systems or via an administrator.

The provider had a clear framework of what was discussed at governance meetings and how this was fed back to staff. Staff participated in local clinical audits and acted on the results when needed.

The senior leadership had a new system in place for maintenance reporting at the hospital. This was an improvement since the last inspection and gave some assurance that environmental issues were being dealt with. Staff knew who to contact to ensure issues reported were acted upon in a timely manner.

Management of risk, issues and performance

The hospital had an overall risk register but not a ward level risk register. Staff could escalate concerns to the risk register via the ward managers. The risk register matched the concerns of staff on the ward and reflected the measures in place on Wimpole ward to pause admissions whilst the processes were reviewed.

The provider was developing systems to ensure that increased admissions to Wimpole ward could be managed safely and effectively. When the ward started to increase patient numbers in December 2019, incidents of aggression between patients started to rise and the provider decided to halt admissions until they had addressed this.

Managers had taken a measured approach towards admitting new patients on the psychiatric intensive care unit and had paused admissions to address the mix of patients on the ward.

Staff on the ward told us that senior managers were supportive of their decision to pause admissions and had not put any pressure on them to accept new admissions until they were confident the ward could be managed safely. The ward had 12 bedrooms, but managers had agreed with staff assessment that flexibility was needed in respect of future admissions to prevent further incidents and maintain a safe environment for patients and staff.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff had access to the equipment and technology needed to do their work, and there were enough numbers of computers available on the wards for staff to update patient records in a timely manner. The service used an electronic system that was easy for staff to use.

Staff made notifications to external bodies as needed.

Engagement

Patients and carers had opportunities to give feedback on the service, either informally at multidisciplinary reviews or through patient satisfaction questionnaires. Carers could also attend a carers forum and an annual support day. Wards had patient representatives who attended a monthly patient council meeting to provide feedback to senior managers from the service.

Learning, continuous improvement and innovation

The service had a site improvement plan in place to identify areas for improvement. The service did not participate in any national accreditation programme.

Requires improvement

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Requires improvement

Safe and clean environment

Staff had completed environmental risk assessments of all ward areas.

Staff could observe patients in all parts of the wards. Staff adequately mitigated risk to patients through convex mirrors, closed-circuit television and staff observations. Ermine and Orwell wards were on two floors, with the bedrooms on the upper floor. Clopton ward was on one level. Those wards with two floors were monitored throughout the day. Staff allowed patients to access all areas of the wards.

The ward complied with guidance on eliminating mixed-sex accommodation guidance and there was no mixed sex accommodation.

There were potential ligature anchor points on the wards. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. There was a ligature risk assessment available on all three wards. Staff knew where to find this and referred to it during inspection. The assessment in place was adequate and an improvement on the last inspection.

Staff had easy access to alarms and patients had easy access to nurse call systems. There were radios available to staff on the wards and they were able to charge these. Staff told us there were adequate amount of radios and they were charged at all times. This was an improvement since our last inspection.

Clopton ward had recently had a serious incident where a patient had done considerable damage to the ward. The damage was to a bedroom, the doors to the outside garden and the dining room. The damage was extensive, resulting in no dining facilities for the patients and no access to the garden area. However, there were two smaller rooms available on the ward with tables and seating which staff were using to offer as a dining area during the meal times for patients. There was a small secure caged area outside, which patients were accessing temporarily for fresh air.

We spoke with the facilities manager of the hospital who provided the site improvement plan in place to rectify this. The estates department were building new door frames for the exit to the garden area. The dining room had some work completed, for example, a new floor had been fitted. Work was still required on the internal door to the servery area. The furniture for the new dining room had been ordered. However, we were not assured that the furniture on order was robust enough and this could have the potential to happen again.

There was refurbishment taking place of bedrooms on the Clopton ward. The décor was tired and in need of decorating. There were plans for this on the facilities work schedule and site improvement plan and dates for this work to go ahead.

Cleaners attended the wards daily and cleaning schedules were completed. On Clopton ward we were told cleaners

also attended in the morning period at the weekend. Staff on Ermine and Orwell wards said they completed the minimum cleaning requirements at weekends, such as emptying bins.

Staff followed infection control policy and handwashing signs were displayed throughout the wards. However, we observed a member staff in the clinic room who had not washed their hands before dispensing medicines.

There were seclusion rooms on Ermine, Clopton and Orwell wards. We were unable to view the seclusion room for Clopton ward as this was in use during our initial visit. We observed staff conducting one to one observations and could hear two-way communication between the patient and the allocated member of staff in this area. On our subsequent visit, we identified a blind spot and ligature risk in the seclusion room and raised this with the provider; the provider addressed these issues after the inspection. We reviewed the two seclusion rooms on Ermine ward which complied with the Mental Health Act Code of Practice. Both rooms allowed clear observation and two-way communication. They had access to a toilet, sink and shower and a clock. There were two low stimulus areas with chairs and specifically designed bean bags for use during restraints.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, we found calibration of equipment was not happening across all wards. However, we found calibration of equipment was not happening across all wards. Whilst a planned visit to calibrate equipment had been cancelled in November 2019, some equipment did not have a date attached and one piece of equipment was due to be recalibrated in June 2016. We found some medical devices had been purchased and not recorded on the hospital assets register, which meant when calibration was scheduled these could be missed. There was no cleaning schedule for cleaning of equipment once used. We were not assured all equipment used was clean prior to use.

We found inconsistencies for the storage of ligature cutters on all three wards. Systems in place varied and different processes were in place. For example, there was a sign on the treatment room door on Clopton ward to say there was a ligature cutter in the room. When we asked a member of staff, they told us it was in a holder behind the door; the holder was in place, but the ligature cutters were not there. Another member of staff told us that they had now moved this to the nursing office. However, there was no signage to let staff know it was in the office and where it was located. We were not assured that staff visiting the wards would know where to access this piece of equipment in a timely manner in the event of an incident of self-harm. On Orwell ward there was a tool box kept in the clinic room which contained a hammer, screw driver and other tools. This was captured on the security check list however, there is no guidance as to how these were to be used and in what situation. We found a drawer in the clinic room at Clopton ward which contained a drill with no specific information as to its purpose.

Safe staffing

The provider reported that the service had 74 substantive nursing staff. This was highest on Ermine ward with 32 and lowest on Orwell ward with 18. Clopton ward had a vacancy rate of 29%, Ermine ward was 26%, and Orwell ward was six per cent. Thirteen members of staff had left the service in the previous 12 months prior to inspection. This was highest on Ermine ward with eight and was lowest on Orwell ward with one. Between 1 July 2019 and 30 September 2019, 812 shifts were filled by bank and agency staff and 38 shifts were not covered. Bank and agency usage was highest on Ermine with 361 shifts and the lowest on Orwell with 195 shifts. Staff sickness across the three wards during this period was over 4%. The highest sickness rate was on Ermine ward at over 5%.

The hospital had in post a full-time workforce co-ordinator who would ensure wards had enough nursing and support staff to keep patients safe. The hospital created staff rotas six weeks in advance. These rotas were revised and updated daily and reflected any change needed. The levels of staffing were reviewed at formal staffing review meetings. The hospital used a staffing ladder to determine how many staff to allocate to each ward. This included increased staffing numbers when observations were required. Wards with two stories, Ermine and Orwell, had been allocated an extra member of staff since our last comprehensive inspection to ensure staff were available on both floors to reduce restrictive practice. Patients and staff told us staffing had improved overall since our last comprehensive inspection.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their

shift. We observed this taking place on Ermine ward during our visit. We spoke with the member of staff who stated they felt equipped to work safely on the ward and care for patients' needs.

Staff could take up to two hours of breaks throughout their shift. The provider had a clear policy that one member of staff could take the last 90 minutes of their shift as a break so long as this did not affect patient safety and there was adequate cover across the hospital.

Staff told us patients had regular one to one sessions with their named nurse. Named nurses for patients were identified on the ward so patients knew who they were. However, one patient told us he was in the hospital for one month before being allocated a named nurse.

Patients had access to escorted leave and activities. We saw evidence of patients going out on Section 17 leave and attending activities whilst on site. We reviewed five days of leave records across all three wards and found 13 episodes of leave which had taken place. This included grounds and town leave, and one patient who attended an optician's appointment. Managers had oversight of section 17 leave through the 'in-charge dashboard', which also evidenced leave had taken place. There were occasions when staff cancelled leave. This was due to incidents on the ward but was also on occasion due short staffing. We saw staff on Clopton ward make considerable efforts to source a member of staff to facilitate a patient's leave during our visit, which went ahead. However, patients told us if there was an incident on the ward which disrupted leave, staff did not communicate the reasons for this well to patients.

The hospital had enough staff on each shift to carry out physical interventions safely. Staff shared key information to keep patients safe when handing over their care to others.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was an on-call doctor who lived on site during the out of hours period. Therefore, calls for cover were responsive to the needs of patients and in the event of emergency, staff told us they would call the emergency services.

Staff had completed and kept up to date with mandatory training. Hospital training records provided showed an overall compliance rate of 90% across the service.

The mandatory training programme met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff completed a range of risk assessments for patients either on admission or soon after and reviewed this regularly, including after incidents. These included the short-term assessment of risk and treatability, the historical clinical risk management tool HCR-20. We reviewed 11 patient care and treatment records for patients. Staff completed the risk assessments in a timely manner to provide details about how to manage patient risk and completed this in line with local policy guidelines. Staff had updated risk assessments to ensure they identified all potential risks for patients assessed as high risk of self-harm.

Staff knew about any risks to each patient and acted to prevent or reduce risks. Potential risks were identified to visiting staff when they arrived onto the wards. Staff identified and responded to any changes in risks to, or posed by, patients. Staff documented this in the patients care and treatment records and documented those risks at multidisciplinary meetings.

Staff followed policies and procedures for the use of observations to minimise risks where they could not easily observe patients, and when they needed to search patients or their bedrooms to keep them safe from harm.

There were 42 incidents of restraint in the previous six months up to July 2019. There had been one prone restraint, this incident was reviewed during inspection and the patient had put themselves into the prone position. Records showed the patient was immediately moved into the supine (face-up) position.

The hospital delivered staff training to prevent and manage violence and aggression. This package does not teach the use of prone restraint. All staff on the wards received this training. The hospital had introduced the safe wards initiative into this package. There was a restrictive interventions reduction programme in place. We observed staff using de-escalation techniques to positive effect.

Staff followed the National Institute of Health Care and Excellence guidelines for rapid tranquilisation in mental health settings.

Requires improvement

Forensic inpatient or secure wards

Staff used seclusion appropriately but did not always document it correctly. We reviewed a random sample of 10 seclusion records across Ermine, Clopton and Orwell wards between 01 July 2019 and 08 January 2020. Most seclusion care plans identified ongoing risk but not how they would be managed. For example, a review stated staff needed to monitor fluids, but the care plan did not specify how. Most plans directed staff to encourage food, drink and physical observation, but there were no directions to support them to meet this. Some care plans stated staff should engage with the patient but had no strategies for de-escalation taken from their personal behaviour support plans.

In one recorded review there was no record of a search being conducted prior to seclusion. We found on more than one occasion, independent multi-disciplinary reviews had not been conducted, and one was conducted approximately 69 hours after seclusion started. Two of the records reviewed had poor recording regarding the termination of seclusion. Two records were not clear that family members had been informed or that advocacy had been offered. However, the records we reviewed showed that patients were offered food and drink at regular intervals and on request. For example, one patient had a takeaway meal out of hours. Patients were given extra blankets and clothing if requested, and those in seclusion for a prolonged period had a change of clothes and their hygiene needs met. Patients were able to make calls, watch television and the records demonstrated engagement with observation staff.

The records we viewed referred to open and locked seclusion. Open seclusion was described as where a patient can move around the seclusion room and de-escalation area and the door is not locked. Patients are prevented from leaving by the presence of two members of staff. Locked seclusion is where the patient is locked in the seclusion room. Whilst the former is least restrictive and was used where ever possible, the term open seclusion is an inaccurate term for this. However, when talking to staff they were clear that this was seclusion and the relevant seclusion safeguards were put in place during this period.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

We were not assured that care and treatment records were updated when required in a timely manner on all wards due to computer system issues. Staff had access to clinical information and stored records securely. On Clopton and Ermine wards, staff we spoke with told us it was easy for them to maintain quality clinical records on the electronic system provided. However, on Orwell ward, staff and managers we spoke with told us the system was slow and ineffective. Problems occurred regularly and the team often relied on one member of staff with IT ability to get the computers running. Staff told us that the day prior to inspection, there was only one computer working on the ward and that this had been the case for the previous two years. Staff had raised this with senior managers, but the issues had not been rectified.

Medicines management

Staff did not consistently follow systems and processes for safely prescribing medicines.

On Clopton ward, we found out-of-date blood bottles. When reviewing prescription charts, we found that staff had not recorded clozapine separately for one patient. Over a 12-week period there had also been 19 medication omissions where an appropriate medication was not provided.

On Ermine ward we found out-of-date blood bottles, one out-of-date cream and a prescribed medication on a trolley which had no patient name.

The provider had not assured that all emergency medicines were easily available to staff. On Orwell ward, we found adrenaline behind the oxygen cylinder on the ward. We raised this with the ward manager at the time of inspection who stated that this had been located there in case of emergency. However, when we reviewed this further, we found a handwritten note stating “EpiPen in emergency

bag". An audit of the emergency bag dated 30 December 2019 had a hand-written note stating, "emergency bag not sealed as EpiPen is missing from bag". Therefore, we were not assured that if an EpiPen was required in an emergency staff could have responded in a timely manner. We also found an insulin pen on the medicines trolley without a name.

The medicines fridge in the clinic room on Orwell ward was broken. There was another fridge which was in good working order, but this did not have a lock. At the time of inspection there were no medicines in the fridge. We found a cupboard which contained 10 different prescribed medicines. We were informed this was stock. However, this cupboard was a general clinic room cupboard and did not meet the specifications required for the storage of prescribed medicines. We raised this with the nurse at the time of inspection who stated this was due to there being no room in the medicines' cupboard provided to store ward stock. Therefore, we were not assured that only appropriately trained and qualified staff had access to those medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Decision making processes were in place to ensure patient's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medication on their physical health according to the National Institute for Health Care and Excellence guidance.

Track record on safety

The service had reported 15 serious incidents in the previous 12 months. Between 1 August 2018 and 1 July 2019. The nature of these incidents included disruptive aggressive and violent behaviour. As a result of this the hospital has implemented the safe wards model. Fifty-nine staff across the service had received training on this model at the time of inspection.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with provider policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when things went wrong.

Managers debriefed and supported staff after any serious incident. We reviewed written evidence which supported this.

Managers said they shared learning with their staff and across the service by global emails, alerts and through team meetings, held with staff on a six-weekly basis. However, when we reviewed minutes from these meetings, this was only evidenced in the meeting minutes for staff on Orwell ward. This was not the case for Ermine and Clopton wards.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The provider employed three physical health nurses across the service to monitor and treat any physical health concerns, with access to local GPs if required. These nurses covered the whole hospital site for seven days a week. However, when we visited on 22 January 2020, two of these staff were off work and it was uncertain when they would return.

Staff developed a plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed. However, we found that care plans did not always represent the patient voice and the language was academic in the way it was written. Care plans were holistic and recovery-orientated and showed detailed future planning.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on National Institute of Health and Care Excellence guidance about best practice. This included access to psychological therapies, such as cognitive behaviour

therapy, schema therapy, mindfulness, mental health awareness and offender specific treatment linked to the patients' offending history. Staff delivered these through groups, one to one sessions and drop-in clinics across the forensic wards.

Staff made sure patients had access to physical health care, such as GPs, chiropodists, dentists and opticians. Staff referred patients to specialist medical services when required. The hospital employed three physical health nurses across all the core services.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We saw evidence of this in the 11 care and treatment records we reviewed.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

We were not assured that there was a full audit programme across the service and that audits that were completed led to change. There was little evidence that staff took part in audits on Clopton and Ermine wards. One clinical audit was completed by the visiting pharmacist which showed areas of concern, requiring action. However, there was no evidence to show what action was taken to resolve them. On Orwell ward, we reviewed care plan audits which staff had regularly conducted and saw evidence of outcomes and actions from audit findings.

Skilled staff to deliver care

The service had a full range of specialists to meet the needs of the patients on the wards, including psychiatrists, psychologists, social workers, occupational therapists, nurses and healthcare assistants.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. This was in line with care certificate standards.

Managers supported staff through regular, constructive appraisals of their work. Hospital records provided showed an overall compliance rate of 100%.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Staff told us this was monthly. However, some staff we spoke with stated that on occasions the provider did not meet this timeframe. Data from the provider showed an overall compliance rate of 82%, below the provider's target of 95%.

Staff also had the opportunity for group supervision at the team meetings, held six-weekly, including a discussion of ward issues, training and reflective practice. However, staff told us no other team meetings were held in that time and staff felt there needed to be an opportunity to meet more than six-weekly to discuss ward level issues.

Managers identified staff training needs and provided time and opportunity to develop their skills and knowledge, using specialist training when appropriate. For example, one nurse was booked to attend nurse non-medical practitioner training. Four members of the healthcare workers team were undergoing their nurse training supported by the hospital. There were opportunities for staff throughout the year to attend diabetes and epilepsy training with the pharmacy team. One team member had just completed a level two mentoring course, and members of the psychology team had applied to attend hearing voices training through the hospital academy and managers supported them to do so.

Managers recognised poor performance through the supervision process, identified the reasons and dealt with these. Hospital records provided evidenced this was the case. In the 12-month period from August 2018 to July 2019 nine staff were managed through supervision and seven staff through the suspension process.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The provider held daily meetings attended by members of the senior management team, doctors and nursing staff. This meeting discussed and dealt with matters arising across the whole hospital, informed by ward managers from daily ward handovers.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We reviewed a random selection of six handover meeting minutes on each ward Ermine, Clopton and Orwell wards which included individual patient information, reviewed observations, any concerns and relevant actions for the oncoming shift.

Requires improvement

Forensic inpatient or secure wards

The hospital and ward teams had effective working relationships with other teams in the organisation and with external teams. For example, the local authority, NHS trusts, local commissioners and the Ministry of Justice. However, we were told by staff, a patient and a carer we spoke with that they were not happy with the decisions made regarding a move for this patient and did not feel the decision was in the patient's best interests. Therefore, they did not feel listened to by the commissioners.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Eighty-seven per cent of staff had received training on the Mental Health Act and the Mental Health Act Code of Practice. Staff we spoke with could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their mental health act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Advocacy representatives attended the community meetings held weekly for patients on the wards.

Staff explained to each patient their rights under the Mental Health Act every three months in a way that they could understand and recorded it clearly in the patient's notes each time.

Staff made sure patients could take Section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice.

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

Managers and staff made sure the service applied the Mental Health Act correctly. The Mental Health Act administrator for the hospital conducted audits and discussed the findings with staff.

Good practice in applying the Mental Capacity Act

Ninety-one per cent of staff received training in the Mental Capacity Act and had a good understanding of the five principles. We saw these principles displayed in locked notice boards on the wards.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw clear evidence of this in all the care and treatment records we reviewed.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Are forensic inpatient or secure wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for patients. We observed episodes of care and interaction with patients and staff during our visit. Patients told us that health care workers and qualified nurses at the hospital listened to them.

Staff gave patients help, emotional support and advice when they needed it. One patient told us that staff helped get his voice back after being mute for a long period of time; they had built his confidence, helped interaction and brought his family together. However, one patient said there had been many staff changes and he did not feel supported by staff.

Requires improvement

Forensic inpatient or secure wards

Staff supported patients to understand and manage their own care treatment or condition and directed patients to other services and supported them to access those services if they needed help. For example, the advocacy service.

Most patients said staff treated them well and behaved kindly. Three patients we spoke with told us that they had a good rapport with the doctors at the hospital. However, two patients raised concerns that some staff were uncaring and could be rude to patients.

Staff understood and respected the individual needs of each patient. However, two patients raised that there is a language barrier between patients and some agency staff.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient information confidential.

Involvement in care

Staff introduced patients to the ward and the services as part of their admission. The wards had a buddy system in place for new patients where a peer supporter was allocated to help orientate them onto the ward.

Staff involved patients and gave them access to their care plans and risk assessments. This had improved since the last inspection. Patients' care planning started on admission with a focus on patient safety first. Patients told us they did receive a copy of their care plans; however, there was still a lack of evidence of the patient voice within the 11 care plans reviewed.

Staff made sure patients understood their care and treatment in ward rounds and in other multidisciplinary meetings. Patients had good access to doctors, who discussed and reviewed patients' care and treatment regularly.

Patients could give feedback on the service and their treatment and staff supported them to do this. Each ward held regular community meetings which were chaired by patients and on occasions attended by senior managers of the hospital. However, meeting minutes we reviewed did not record feedback and outcomes.

Staff made sure patients could access advocacy services. An advocate attended the community meetings and patients told us this service was always available to them.

Staff supported, informed and involved families or carers. We received feedback from five carers of patients. We were told staff were proactive in maintaining contact between families or carers and patients and felt supported and informed. One carer we spoke with was unhappy about a pending move and felt that the hospital was the best place for her relative. This discussion was ongoing. The hospital held an annual carers forum and family open day. There was a Christmas meal provided for those patients and carers who wished to have Christmas dinner together.

Staff helped families to give feedback on the service. This was through carers meetings. Feedback could be sent by email to the hospital. Staff gave carers information on how to complete the carer's assessment if required.

Are forensic inpatient or secure wards responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Between August 2018 and July 2019, the average bed occupancy was 95% on Clopton ward, 87% on Ermine ward and 97% on Orwell ward. The provider submitted a data set of the average length of stay for the current patient group, this was at its highest on Orwell ward at 1413 days and the lowest on Ermine ward at 351 days.

The wards accepted patients from out of area. Staff discharged patients to suitable placements nearer home if possible.

When patients went on leave there was always a bed available when they returned.

The hospital only moved patients between wards when there were clear clinical reasons, or it was in the best interest of the patient. For example, one patient was located on another ward for safeguarding reasons. However, another patient required seclusion and the patient needed to move to another ward for this need to be met. Staff said this was challenging at times as the patient still belonged to their original ward and staff did not feel they were fully up to date with the patient's care.

Requires improvement

Forensic inpatient or secure wards

In the previous 12 months, the hospital reported one delayed discharge. Staff supported patients when they were referred or transferred between services. The hospital followed national standards for transfer.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom, which they could personalise. For example, we saw patients' bedrooms with photographs displayed, drawings and personal items. Patients could store possessions on the wards. The provider used rooms as store cupboards which patients did not have access to.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access their rooms. There were rooms for meeting visitors just off the wards.

Patients could make phone calls in private. All patients were allowed personal mobile telephones; these were basic with no access to the internet to mitigate potential risk. The wards had a phone available for patient use at any time.

The wards had an outside space that patients could access. However, patients on Ermine ward had no access to the garden area following a serious incident when the exit doors were damaged. Instead, patients accessed a small outside area until this had been repaired. We raised this with the facilities manager who provided supporting evidence and assurance that plans were in progress to rectify this as quickly as possible.

Patients could make their own hot drinks and snacks and were not dependent on staff. On Ermine and Orwell wards this was available on both floors.

The service offered a variety of good quality food. Patients could request vegan and vegetarian food when needed, although menus did not consistently contain vegan options. Patients told us the food quality and choices were good. However, one patient stated it had been the same menu choices for up to two years.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients to apply for these opportunities.

Staff supported patients to stay in contact with families and carers where appropriate.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff did this by escorting patients on community leave once risk assessed and authorised to do so.

Meeting the needs of all people who use the service

The service could not support or make adjustments for disabled people with significant mobility issues. Two of the wards, Ermine and Orwell, had bedrooms located upstairs. Clopton ward was on one level. However, after 5pm and at weekends, the ward used a different access point to enter and exit the ward which meant patients had to go upstairs then down again to access reception. The hospital did not have a lift available to patients. Managers considered these issues when accepting admissions.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The hospital did this by using notice boards on the wards. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us they could access information leaflets available in other languages spoken by the patients and local community if there was a need.

Staff offered patients a range of culturally appropriate food including Kosher, Halal and vegetarian options. Staff ensured that patients had access to spiritual, religious and cultural support. A service was delivered weekly by the chaplain and a local imam visited the hospital to speak and pray with Muslim patients.

Listening to and learning from concerns and complaints

The hospital had systems for the recording of complaints. When staff received a complaint, managers wrote to the complainant to acknowledge receipt and explained the process.

Patients knew how to complain or raise concerns and had the opportunity to raise concerns at the community meeting held weekly on the wards for patients.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

Requires improvement

Forensic inpatient or secure wards

Between 1 August 2018 and 1 July 2019 there were 22 complaints across the three wards. Six for Orwell, four of which were not upheld and two partially upheld; nine complaints for Clopton ward, six of which were not upheld and three were partially upheld. Ermine ward had seven complaints, three of which were upheld and four were not. We found there to be a theme within the complaints on Clopton ward regarding the environment. Hospital managers had identified this theme and complaints referring to this were partially upheld and identified on the site improvement plan. As a result, there was a new maintenance log put in place. Staff said this was much more efficient and an improvement on the previous system.

We reviewed 11 complaints across the service, and we found acknowledgment letters and apologies sent to the complainant regarding staff not meeting timescales. One complaint upheld was not clear in its recording. However, we did see learning included in the complaints we reviewed.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

The service had received 41 compliments in the period 1 August 2018 to 1 July 2019. The provider used compliments to learn, celebrate success and improve the quality of care.

Are forensic inpatient or secure wards well-led?

Requires improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Leaders understood the services they managed, and particularly the challenges they face with the ward environment following recent serious incidents on Clopton ward.

Managers had ensured staffing figures had improved since our last inspection. However, there were 12 occasions over a six-week period when shortfalls were covered by the ward manager and not an additional member of staff. Therefore, we were not assured that at those times managers could conduct their managerial tasks effectively.

Leaders were visible in the service and approachable for patients and staff. We were told that senior managers visited the ward much more regularly and staff felt more confident and optimistic about the future. Staff told us they felt more valued and listened to.

Leadership development opportunities were available, including opportunities for staff below team manager level. The provider had staff in post undertaking their nurse training supported by the hospital.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. These were permanently displayed on the home intranet page of the hospital for all staff. The hospital also highlighted the seven C's of care, compassion, competence, communication, courage, commitment and consistency. The senior leadership team had communicated this to all staff, and this was evident in staff supervision. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.

Staff had the opportunity to contribute to discussions about the strategy for their service, through team meetings, your say forums and head office listening events.

Culture

Managers had removed institutional practices from this service, such as periods when patients could not access their bedrooms at certain times of the day. Managers ensured there were more staff available to supervise these areas.

The senior leadership team had ensured that any complaints regarding staff attitude towards patients were investigated and managed appropriately. Managers provided evidence to support this where staff had been moved from the ward during investigation. In cases where there was clear evidence of concern, staff had been suspended for the matter to be investigated. Patients spoke highly of staff and their attitude towards patients of listening and wanting to help.

Staff felt respected, supported and felt more positive and prouder about working for the provider and their team.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process. Posters were displayed giving clear guidance on how to do so.

Managers dealt with poor staff performance when needed through the supervision process. We saw evidence of a thorough performance improvement plan for a member of staff who stated they were pleased to have had this support. This had given them guidance and they felt this had made them much more effective in their role and they had learnt from this. The staff member was open, transparent and believed this was supportive and did not feel this was punitive.

Managers discussed professional and career development with staff at appraisals and supervision. For example, nurse training and enabling training for registered nurses to become medical prescribers.

The provider employed an equality and diversity lead to support staff and develop the equality and diversity strategy. Due to some concerns of racial abuse toward staff the hospital had introduced joint working with police about anti-social behaviour and hate crime. A working party was in place to support staff.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The service's staff sickness rate across the three forensic wards was 5%.

Governance

The senior leadership team had not addressed all areas of concern since the last comprehensive inspection. For example, there were still issues in relation to medicines and the clinic rooms which have been raised in the last two inspection reports. Managers had not ensured there was an effective process in place to ensure that clinic rooms were organised, and that equipment was sufficient and in good working order. Pharmacists conducted regular audits in relation to the clinic rooms and issues identified and reported to the hospital, but managers had not ensured that they had acted on these findings.

The provider had not ensured that staff had completed seclusion paperwork in line with the Mental Health Act Code of Practice.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However, we reviewed team meeting minutes and two out of three ward minutes did not reflect these discussions. In addition, staff told us that meetings were infrequent. Therefore, we could not be assured essential information was being shared with staff.

The senior leadership team did not ensure staff undertook or participated in local audits. The audits were limited and did not always provide assurance that staff acted on the results when needed. We saw evidence that ward managers discussed pharmacy audits in clinical governance meetings. However, these were not acted upon consistently following these discussions.

The senior leadership had a new system in place for maintenance reporting at the hospital. This was an improvement since the last inspection and gave some assurance that environmental issues were being dealt with. Staff knew who to contact to ensure issues reported were acted upon in a timely manner.

Staff acted on concerns from incidents, safeguarding referrals and complaints raised by patients and carers. Managers tried to find solutions to difficulties where possible.

Management of risk, issues and performance

Ward managers could raise concerns and put these onto the hospital's risk register. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.

The service had plans for emergencies, for example, adverse weather or a flu outbreak.

Information management

Staff on Ermine and Clopton had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, the electronic records system was ineffective on Orwell ward. Staff and managers told us the system was slow with problems occurring regularly. The team relied on one member of staff with IT ability to get the computers running. Staff we spoke with told us that the day prior to inspection there was only one computer working

on the ward. Staff we spoke with, told us this had been the case for the previous two years. This had been raised up to senior manager level and no action had been taken. Therefore, we were not assured that care and treatment records were updated in a timely manner due to computer system issues.

Managers had access to information to assess team performance. This included mandatory training, supervision and appraisal compliance. Managers used this to ensure staff were up to date. Systems used to collect information did not place a burden on frontline staff.

Staff made notifications to external bodies as needed. We saw evidence where staff had reported safeguarding concerns.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, and emails and newsletters. The newsletter had four priorities within it. This was, recruitment, retention, systems and processes.

Patients and carers had opportunities to give feedback on the service they received. Patients raised concerns with managers at community meetings. Senior leaders would also attend these meetings if requested by patients. There were monthly service user council meetings, attended by representatives from each ward and by senior managers. Carers fed back though quarterly meetings, an annual support day and regular care programme approach meetings.

Managers and staff responded to concerns raised by patients through service user's council meeting and these were documented. Community meetings did not always record outcomes of concerns raised by patients. We reported this at previous inspection visits and managers have failed to respond to this.

Senior managers and ward managers engaged with stakeholders such as commissioners and NHS England.

Learning, continuous improvement and innovation

Staff had participated in a schizophrenia audit in the previous 12 months prior to inspection.

The hospital participated in and had received the Royal College of Psychiatrist's accreditation for the Quality Network for Forensic Mental Health.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

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

Inadequate

Safe and clean environment

Not all ward environments were safe for patients and staff . We found cables on Nightingale ward which a patient at risk of self-harm or suicide could use to tie a ligature. A ligature is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. These cables were not on the environmental risk assessment. We informed the ward manager, who acted to reassess the ward environment for further risks.

Housekeeping staff cleaned ward environments regularly and kept records to show this. However, most environments needed redecoration and some surfaces had degraded to the point where staff could not clean them properly. The provider showed us quotes for their plans to refurbish the wards, but they did not have a clear date for when they would complete this.

Staff followed infection control procedures; the provider made alcohol gel available at the entrance of the wards and throughout where appropriate. However, staff on Swift and the Bungalows did not have a dedicated space to wash their hands when conducting physical examinations and had to use the sinks in the toilets, which could be an infection control risk.

We found blind spots in one of the bungalows which prevented staff from observing all parts of the ward. Staff told us that the provider had ordered convex mirrors to mitigate the risk presented by the blind spot. However, this did not fully mitigate the risks to staff or the patients.

The environment in the Bungalows had limited space for staff to manoeuvre safely if they needed to restrain a patient in the corridors. Staff had assessed that one of the patients who lived there displayed a number of behaviours that challenged. The provider told us they were adjusting the ward environment with the patients in residence, including building a fence for privacy and introducing furniture and electricals.

The ward environments were well furnished, and furniture was in good repair. A dedicated team ensured the maintenance of each ward and whilst there were some areas in need of repair, we saw clear evidence of how the team were managing this. Staff completed environmental risk assessments, but these did not identify all the risks that the environment presented to patients. For example, a ligature risk and the limited space in the bungalows to restrain patients if needed.

Space on Wortham ward was very limited. Corridors and some communal rooms were small, and with limited space for staff or patients to have private conversations. The provider showed us plans to make changes to the ward environment to provide more space and facilities. At the time of inspection this work had not been completed.

The service did not have any mixed sex accommodation.

Staff had access to personal safety alarms on each ward. We tested the functionality of these alarms during our inspection and found them to work appropriately. Patients had access to nurse call alarms.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

We found inconsistencies in physical health monitoring equipment and the provision of a suitable clinical space for examinations and procedures. Nightingale, Fairview and Wortham ward had dedicated clinic rooms where staff could undertake physical examinations of patients and prepare medicines. We saw records which showed staff cleaned rooms and equipment regularly. There was no dedicated room on Swift and the Bungalows and staff stored and prepared medicines in the staff office. Staff had access to green bags which contained all items which staff would need to monitor patients' physical health, however we found on the Bungalows there were items missing from these bags.

Emergency medical equipment was not always easily available. Not all staff were aware of where the emergency medical equipment was stored and the signage was not clear on where the equipment was stored. We were concerned that staff would not be able to access the equipment when required, potentially placing patients at risk. The bungalows shared a red emergency bag, which contained a defibrillator and other items for use in a physical health emergency. Swift ward shared an emergency bag with another ward. However, one of the bungalows had a sign directing staff to a bungalow which did not contain the emergency bag. The member of staff on Swift ward could not tell us where they would access a bag in an emergency. We raised this with the provider during the inspection, who put measures in place to address this.

The de-escalation area on Nightingale ward was originally a seclusion room but had been decommissioned in 2018. However, the provider continued to seclude patients in this room for short periods. Between 22 July and 31 December 2019, there were five episodes of seclusion in this room, involving two patients. The room had suitable toilet facilities, furnishings and privacy. However, we found some potential safety hazards, for example, the mechanisms on the viewing panel of the toilet door protruded and would be a risk to anyone attempting to self-harm through head banging.

Safe staffing

The rehabilitation wards had a staff establishment of 75 staff. The staff turnover rate between August 2018 and July 2019 was 24.5%. The provider did not give a reason for this high turnover rate. In the same period, the staff sickness rate was 3.3% with two staff on long term sickness.

The provider used 'staffing ladders' to calculate the minimum number of staff they needed on the ward. Managers reviewed this daily in meetings and adjusted these numbers according to patient needs and risk. We saw evidence across all wards where managers had adjusted staff numbers to account for increased patient risks or because of a need due to the ward environment.

Staff could take up to two hours of breaks throughout their shift. The provider had a clear policy that one member of staff could take the last 90 minutes of their shift as a break so long as this did not affect patient safety and there was adequate cover across the hospital. However, staff told us when other staff left early to go home at the end of the shift, wards could be short staffed, particularly if there was an emergency and staff needed to be summoned quickly.

The provider used agency staff on the wards. The vacancy rate across the service was 15%. Between 1 July 2019 and 30 September 2019, the provider filled 607 shifts using agency staff across the service. Managers recognised the need for the patient group to have familiar staff who knew their needs and how to manage their behaviours. Therefore, when they needed to use agency staff, they block booked them for a period of time and ensured they provided a thorough induction.

Managers sometimes used bank staff and staff from other wards to fill gaps in staffing. We found the orientation for these staff was insufficient as staff on Swift and the Bungalows were not familiar with where to find essential items on request.

All patients had a primary nurse who spent regular one to one time with them. We saw evidence in patient notes that these sessions were happening and were of good quality.

Patients rarely had their leave cancelled because there were not enough staff on the ward. We saw that in the three months prior to the inspection staff had cancelled leave 10 times. This was usually for reasons other than staffing and they always arranged for patients to take their leave later or on a different day.

Each ward had access to one or more regular consultants who could attend the ward during working hours. Out of working hours, the provider operated an on-call rota, where staff could phone a doctor on site to attend or get advice over the phone. There was an on-call doctor who lived on site during the out of hours period.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Mandatory training compliance was low across the rehabilitation wards. Managers accessed records of the training which staff had completed on the online academy. This showed several areas where training compliance had fallen below the 75% target the provider expected. Topics included fire safety, introduction to learning disabilities, managing challenging behaviour, rapid tranquilisation, incident reporting, safeguarding and clinical risk assessments. Several of these topics were essential skills which staff needed to work safely on the wards.

Assessing and managing risk to patients and staff

Staff assessed individual patient risks well. All patient records reviewed during our inspection showed that staff had undertaken a thorough risk assessment of the patients' risks on admission, using a standardised risk assessment tool. Staff had regularly reviewed these records and updated any new risks.

Staff were able to identify patients who were at risk of pressure ulcers or falls and monitored these patients.

Staff knew how to respond to changing levels of risk in a person-centred way. We observed staff completing situation-based risk assessments, for example when patients were going out on unescorted leave. Staff followed provider procedures when they needed to search patients when returning from leave. Staff used observation of patients appropriately to ensure they were safe. Staff kept detailed records and followed guidance and provider policy.

Staff used blanket restrictions on Nightingale and Wortham ward to manage risk. On Nightingale, the ward environment had floors and staff required patients to be out of their bedrooms and downstairs for two hours in the morning. Staff locked the door to the upstairs portion of the ward for this time, preventing patient access. Staff we spoke with told us this was to ensure patients washed or showered and to enable housekeepers to clean patients' bedrooms. On Wortham ward, staff locked the door to the outside area and patients had to ask staff for access. Some patients fed back that often staff were too busy to let them outside. Staff we spoke with said that the fence surrounding the outside space was not high enough to prevent patients from absconding from the ward.

Staff applied the smoke free policy appropriately, communicated changes to patients through community meetings and offered patients advice to stop smoking and nicotine replacement therapy.

The wards all displayed signs to tell informal patients they could leave at will and where appropriate, staff left doors unlocked during the day to allow freedom.

Episodes of seclusion had increased since the last inspection. Between August 2018 and July 2019, the provider reported seven episodes of seclusion, all of which were for one patient on Nightingale ward. The provider did not report any long-term segregation in this period. Managers had recently admitted a patient to a single-person service on the Bungalows.

Ward staff participated in the provider's restrictive interventions reduction programme and had completed safe wards training to reduce conflict and aid de-escalation. However, use of restraint on rehabilitation wards had increased. Between August 2018 and July 2019, across five of the rehabilitation wards, there were 42 episodes of restraint in relation to 12 individual patients. This had doubled since the previous inspection. We did not see any evidence that any analysis had been made to determine the causes of this increase and take steps to reduce the number of restraints across the service. The wards reported one episode of prone restraint. The patient was immediately turned to a face up position. Staff had access to specifically designed bean bags if they needed to restrain a patient face-up. Staff were not trained to restrain patients in the prone (face-down) position. At the time of the inspection 67% of staff were up to date with breakaway training. This meant that not all staff had received training to carry out restrictive interventions or keep themselves and patients safe on the wards.

Staff followed provider policy and used de-escalation techniques when patients were exhibiting challenging behaviour. We observed that staff on the wards knew their patients well and understood what to do to de-escalate situations.

Staff did not keep accurate records of seclusion. We reviewed five records, three of which showed discrepancies between times and one showed a delay in a doctor arriving to review the seclusion. All patient's records included a seclusion care plan. However, three did not meet the

standards laid out by the Mental Health Act Code of Practice in relation to the management of risk and directions to staff about engagement and de-escalation strategies with patients.

Safeguarding

Staff compliance with safeguarding training was 74% of staff across all wards for both safeguarding adults and safeguarding children. It was unclear from data provided what level of training these figures encompassed.

Staff we spoke with understood how to identify abuse and could give examples of when they had raised concerns and worked in partnership with local authorities to protect patients. The provider had a safeguarding lead on site and posters of how to contact them on each ward along with a list of contacts for the local authority.

Some wards did not have spaces where children could visit their relatives safely. However, staff were able to book a room off the ward to facilitate visiting, if needed.

Staff access to essential information

Staff used an electronic records system to record information about patients' care. However, this system was slow, and it was not always clear where staff had saved records. We asked staff on three wards to help us find patients' discharge plans, and they were unable to locate them on the system.

Medicines management

Staff did not always follow best practice guidance when managing patients' own medicines. Staff had not labelled medicines for patients on Nightingale and Wortham wards with the patient's names, for example, insulin, inhalers and a nasal spray. There was a risk that staff could give someone another patient's medicine which could spread infection or cause harm.

Staff did not always prescribe medicines in a consistent manner. On Fairview ward and the Bungalows, we found prescription cards which did not include the date that the doctor had transcribed the prescription. It was therefore unclear when the doctor last reviewed the medicine. This was different to all other wards where the doctor did include the date, they had transcribed the prescription. There was a risk that staff could become confused if more than one prescription chart was in circulation and may give additional or incorrect doses of medicines. We raised this with the provider for clarity on their policy. The provider did not have specific guidance for which date the doctor should use but assured us that they had made changes to ensure there was consistency across the service.

Staff ensured that they stored medicines in locked cabinets or fridges and monitored the temperatures. They completed regular expiry date checking and kept records. Staff stored and managed controlled drugs appropriately. The service had an appropriate method to cascade alerts for medicines and medical devices.

Staff encouraged patients to manage their own medicines where appropriate. They supported this as an essential skill to aid patients' recovery. Staff assessed patients who managed their own medicines and offered different levels of support depending on their needs.

Staff did not consistently monitor side effect of patient's medicine. On Nightingale we saw evidence that staff were completing side effect monitoring for medicines using tools such as the Lester tool and the Liverpool University Neuroleptic Side Effect Rating Scale. However, on the Bungalows and Wortham ward, we found that staff were not correctly completing forms for monitoring three patients on clozapine. Staff should regularly monitor patients taking clozapine and other antipsychotic medicines to ensure their physical health is not deteriorating because of the medicines they are taking. Monitoring should include regular physical health checks and monitoring of any physiological side effects they are experiencing.

Track record on safety

Between August 2018 and July 2019, the provider did not report any serious incidents. There had since been one serious incident.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew what incidents to report and how to report them. The provider used an electronic incident reporting system. Staff reported a variety of incidents and managers reviewed and responded to the incidents in a timely manner. The provider offered training on how to use the incident reporting system. This was not mandatory, but uptake was 60%.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff understood their responsibilities under the duty of candour and were able to explain actions they would take in the event of an incident and give examples of types of incidents. We were not able to review any evidence of them doing this as no incidents had required this.

Managers shared information about lessons learned from incidents to staff through email bulletins and posters. Staff signed to agree that they had received them. Staff also met to discuss incidents at staff meetings every three months. However, we reviewed minutes from these meetings and found they were sparse and staff who were unable to attend would not have been aware of what the group had discussed. Staff we spoke with were not able to give examples of safety improvements which they had made following incidents.

Staff could receive a thorough debrief following any serious incidents. Depending on the severity of the incident, a senior management in conjunction with a psychologist or a ward manager chaired them.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff completed an assessment of each patient's needs on admission to the ward. Of the 16 records we reviewed most patients had a personalised, holistic and recovery orientated care plan. The plans were all regularly updated and included the patient in the decision making.

Staff assessed the physical health needs of patients on admission but did not always monitor their health or identify when their condition was deteriorating. We found evidence of four patients on the rehabilitation wards with long term health conditions which specialists had identified, staff had clear instructions on how to manage their conditions including; daily monitoring, follow up appointments and regular assessments. However, we found that staff were not completing these instructions as advised. One patient needed six times daily monitoring of their blood pressure and heart rate, but staff only completed this three times a day. Another patient was due a routine blood test for their condition which was a year overdue. Two other patients declined treatment for their long-term conditions but staff from the physical health team did not monitor them for signs of deterioration of health. Staff assessed the mental capacity of these patients appropriately.

However, one patient had an acute condition which their medicines may have caused but staff had not identified this, monitored the condition well or escalated concerns. The patient was subsequently admitted to hospital for this condition. Staff had identified they needed to follow infection control procedures for another patient on admission, however they had continued to follow these procedures for several months without testing to see if the patient was still at risk. Staff had partially completed a physical health assessment for one patient which was inaccurate and required completion and review by a nurse; this record was three months old but had not been signed off.

Best practice in treatment and care

Staff provided a range of treatments suitable to the needs of patients. This included psychological interventions overseen by a clinical psychologist, a forensic psychologist and staff support, developing skills needed to be self-sufficient, such as shopping, cooking, self-care, laundry and budgeting. However, some care was not focused towards rehabilitation in this service. Staff did not encourage some patients to fully participate in activities which could help their recovery. Staff we spoke with told us this was because they believed these patients were unlikely to be discharged.

Senior staff met on a regular basis to discuss new guidance and ensure that they were offering all appropriate treatments.

Staff ensured they met patients' nutritional needs and monitored their weight and fluid intake where appropriate. The service had access to a dietitian to support any further needs.

Staff encouraged patients to live healthier lives by educating them on food choices, running walking groups and supporting them to develop exercise habits and stop smoking. Staff provided patients with information about stopping smoking and substance misuse.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff used recognised rating scales such as Model of Human Occupational Screening Tool and Health of the Nation Outcome Scale to measure the severity of patients' conditions and the progress they were making in their treatments. They used these outcome measures to develop personalised care plans.

Staff undertook a range of clinical audits to ensure the safety and effectiveness of the service. Regular topics included infection control, safeguarding, clinical supervision and implementation of outcome tools.

Skilled staff to deliver care

The wards had access to a range of specialists to meet patients' needs. This included nurses, healthcare support workers, psychiatrists, psychologists, occupational therapists and activity co-ordinators. A dentist visited every 2 weeks and a chiropodist every six weeks. The teams also had access to a sessional speech and language therapist and a part time dietician. The team did not include a dedicated social worker.

Staff were sufficiently qualified and experienced to do their job. However, nursing and support staff we spoke with told us they did not have access to additional rehabilitation focused training. Staff supporting patients with learning disabilities or autism had access to support from a clinical psychologist and learning disability nurses. However, not all staff had received specialist learning disability training.

Recovery support workers offered a range of meaningful activities on a weekly basis.

The provider employed three physical health nurses across the service to monitor and treat any physical health concerns, with access to local GPs if required. These nurses covered the whole hospital site for seven days a week. However, when we visited on 22 January 2020, two of these staff were off work and it was uncertain when they would return.

The rehabilitation wards had referred 38 patients in the three months prior to the inspection, and the team had seen the 90% of patients who had consented to attend. However, some patients had long term conditions which the physical healthcare team were not appropriately monitoring through these clinics.

Staff had regular, six-weekly, team meetings to discuss topics and case studies. Staff we spoke with told us they did not feel this was sufficient. Managers attended a daily handover meeting with other managers in the hospital and shared relevant information with staff on the wards.

At the time of the inspection, 89% of staff had had their annual appraisal. Managers set specific and measurable goals for staff during appraisal which they mapped against the provider's values. Managers used appraisals to identify staff learning needs and to support their career progression. We saw that managers had supported staff to work towards a promotion or learn specialist skills which would be useful in their careers such as phlebotomy and catheterisation training.

Managers ensured staff had regular clinical and management supervision. Staff had compulsory clinical supervision in three monthly meetings and 83% of staff had received management supervision in line with the provider's policy. However, we found the quality of some management supervision was not consistent and managers did not always set actions or carry them over.

Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

Members of the multi-disciplinary team met on a regular basis to review patients' progress. Every six weeks, staff from the team would meet with patients to update their care plans and activity plans for the following six-week period. These meetings were attended by most members of the multidisciplinary team but did not include healthcare support workers. Healthcare support workers attended handover meetings which provided updates on the patients' progress.

Managers attended a site wide handover meeting at the start of each day, where they discussed incidents, staffing and any special requirements each ward had for the day. Although more junior staff from the wards did not attend these meetings, managers cascaded this information to staff working on the wards in written form which staff read and signed.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff in the multi-disciplinary team worked well together. We observed staff working in collaboration to plan patients' care in the ward review meetings. These meetings included relevant staff from external organisations such as the patient's care co-ordinator.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Not all staff were not up to date with their training on the Mental Health Act. The provider offered training through their online training system. However, managers provided training data during the inspection which showed that only 72% of staff had completed this training.

Staff had access to an administrative support team who offered advice to staff and audited to ensure their compliance with the Mental Health Act. The provider had a Mental Health Act policy which was readily available to staff on the intranet.

Staff made patients aware of their rights under the Mental Health Act. We saw clear evidence of staff informing patients of their rights and recording this appropriately on the electronic notes system.

Patients had access to specialist Mental Health Act advocacy services which staff advertised using posters on the ward.

Staff ensured that patients could take their agreed section 17 leave under the Mental Health Act. Some patients told us that staff had cancelled their leave at times due to short staffing. However, the provider had documented this and had showed when they had rearranged this leave. The wards displayed signs to tell informal patients they could leave at will.

Staff sought approval from a Second Opinion Appointed Doctor (SOAD) when detaining patients under the Mental Health Act and kept records of this paperwork with the patient's notes.

Staff devised appropriate section 117 aftercare plans for patients when planning for their discharge.

Good practice in applying the Mental Capacity Act

Not all staff were not up to date with their training on the Mental Capacity Act. The provider offered training through their online training system. Managers provided training data during the inspection which showed that only 66% of staff had completed this training. However, staff we spoke with demonstrated a thorough understanding of the Mental Capacity Act and its principles.

Staff had a good understanding of the five principles. We saw these principles displayed in locked notice boards on the wards.

The rehabilitation wards did not have any patients who were subject to a Deprivation of Liberty Safeguard.

Staff had access to an administrative support team who offered advice to staff and audited to ensure their compliance with the Mental Capacity Act. The provider had a Mental Capacity Act policy which was readily available to staff on the intranet.

Staff supported patients with capacity to make their own decisions. We saw several examples of occasions where staff had supported patients to decide and had recognised their right to make an unwise decision. Staff assessed and recorded patients' capacity to make specific decisions and revisited this regularly. Where patients did not have capacity to make their own decision, staff made appropriate best interest decisions, sought the views of those closest to the patient and considered the individual's wishes.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Staff respected patients and treated them with kindness, dignity and respect. Most patients and family members we spoke with felt that staff were always kind and respectful and had their best interests at heart.

Staff supported patients to manage their own care and helped them to access services which could support their care. They encouraged patients to attend services outside the hospital where appropriate and helped them to access

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

support from external organisations when needed. With the exceptions of some blanket restrictions on Wortham and Nightingale wards, staff treated and cared for patients in an individualised way.

Patients felt comfortable raising concerns about abuse and unfair treatment and said staff were responsive when they did.

Staff respected patients' privacy and confidentiality.

Involvement in care

Staff orientated patients to the ward when they admitted them and gave them information about their care and treatment. Most patients said staff had shown them around when they were admitted to the ward. All patient records that we reviewed showed evidence that staff had included the patient in their risk assessment and that the patient had been involved in developing their care plan.

Staff communicated their plans to patients through offering them copies of their care plans and inviting them to review meetings. Staff listened to patients during review meetings and considered their views on their care.

Staff took feedback from patients on how they could improve their care. They collected this feedback during weekly community meetings which gave them a chance to request changes and activities. We saw evidence that staff recorded and acted on these requests in community meeting record books and on 'You said, we did' boards on each ward.

Staff supported patients to make advance decisions about their care when appropriate. We saw evidence of advance decisions in patient records where staff recorded the patient's wishes appropriately.

Patients had access to advocacy services. The wards displayed the phone number of the advocacy service in poster form and all patients we spoke with were aware of how to request a visit.

Staff involved family members in the patient's care when appropriate. Staff sought consent from the patient to involve family members and respected their wishes if they refused. Most records we reviewed showed evidence of family involvement in the risk assessment and the care plan. Staff invited family members to the monthly ward reviews.

Staff took feedback from family members. We saw feedback forms from a carer's day the provider had arranged to provide patient's families with information about the hospital. Most family members we spoke with said they had been given the chance to feed back to the service about their relative's care.

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

Good

Access and discharge

At the time of the inspection, all wards had available beds. Staff told us that the wards were rarely full. Between August 2018 and July 2019 Nightingale and Wortham wards admitted 5 patients each. On average, patients on Nightingale waited 117 days to arrive on the ward and patients on Wortham waited 29 days. This was due to the need for funding agreements, pre-admission meetings and issues on the wards which the provider needed to resolve prior to admission.

Staff ensured that there was always a bed for patients to come back to when they returned from leave. We saw that staff had kept patient's bedrooms as they were when they were on an extended period of leave from the ward.

Staff only moved patients between wards when justified. Examples of when staff moved patients between wards were; when patients had reached a suitable point in their recovery that they could be moved to a less secure setting such as the Bungalows, or when they had experienced a deterioration in their health which meant they needed more intense staff input.

Patients often stayed longer than planned. Staff told us that the model of the wards expected patients to stay for lengths of time between six and 18 months. However, average length of stay data showed that patients stayed for an average of 83 months. This data included seven patients who had transferred to less secure settings within the hospital.

Staff made suitable discharge plans for patients. All patient records we reviewed had thorough discharge plans.

However, we found that staff often had difficulty locating this information on the system when asked. Some staff were not able to tell us about how they planned for discharge. Discharge plans included relevant goals to measure progress towards discharge and plans for a suitable time to discharge. Staff from this service could attend a new placement with a patient to help them settle in and to ensure continuation of their care.

Staff followed transfer of care standards when transferring patients between healthcare settings. We saw clear documentation in notes of how staff had transferred patients to acute hospitals and new placements with all information necessary for their care.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms which they could personalise and could store their possessions safely. Each patient had their own bedroom with a hand basin for washing. Rooms were not en-suite and patients had to share toilet, bathroom and shower facilities.

We saw that some patients had put up posters and brought in their own bedding to make their room their own. All wards had lockers which patients could use to store their belongings and most patients could lock their bedrooms with their own key. Some patients on Nightingale and Wortham did not have a key for their bedroom. Staff told us they were trying to obtain keys for patients, but it was taking longer than expected as the keys were difficult to cut.

Ward environments were not consistently therapeutic and did not always promote the comfort of all patients. Wortham ward was a tight space with a potential for 17 patients and staff restricted access to outside areas. Staff used the computer room to store patients' personal property as they had no other storage space available. On Nightingale ward, the outside area had high fences which gave the impression of a secure mental health unit rather than a rehabilitation ward. Background noise levels on the wards were high and included regular conversations on two-way radios and visitors ringing doorbells multiple times as staff were not able to attend to them quickly. This could impact negatively on patients with noise sensitivity or social anxiety. However, the wards had access to a range of rooms to meet their needs, including quiet rooms, private spaces to meet families and rooms for review meetings.

Patients could usually make a phone call in private if they wished. Most patients had access to their own mobile phones and each ward had a telephone in a cubicle. The exception to this was in the Bungalows where the telephone was in the hallway.

Patients could not always access outside spaces at will. On Nightingale, Fairview, Swift and the Bungalows, staff left the doors to the outside spaces unlocked. However, on Wortham staff kept the door locked because the fence was not high enough to prevent patients absconding. Staff told us that patients could request to go outside whenever they wanted, however, patients told us this was not always possible as staff were too busy.

Patients could access the onsite farmyard where they could care for pigs and chickens.

The wards did not offer a varied menu to cater for all patients' needs. We reviewed 14 weekly menus; eight did not contain a vegan option, although the rehabilitation wards had patients who were vegan. Whilst staff were able to request special vegan meals, patients fed back that this was sometimes a plate of vegetables. Patients could make hot drinks and snacks any time. Staff on Nightingale ward did not allow patients access to caffeinated drinks after 10pm.

Patients' engagement with the wider community

The provider ensured that patients had access to education and work opportunities. Some patients volunteered at a charity shop or an on-site café. Patients were also able to access vocational training and one patient had gained qualifications.

Staff supported patients to access the local community, including local public services such as the gym and the library and arranged trips to local towns. They ran a varied programme on the wards. Patients could participate in activities such as pool, table tennis, knitting, gardening, and animal husbandry, as well as gaining skills they needed for life such as shopping, cooking and laundry.

Staff ensured that patients maintained relationships with their families and the people that mattered to them. The provider ran regular family days, included family members

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

in ward reviews and facilitated visits to the ward or outside of the hospital. Staff maintained relationships between patients on the wards by facilitating regular, mediated community meetings where patients could raise concerns.

Meeting the needs of all people who use the service

The provider did not ensure that patients with mobility needs could access the ward environment. Spaces for patients were not always suitable for disabled access. Swift and Nightingale wards did not have downstairs bedrooms. However, all wards had disabled ramps and the provider placed patients with mobility needs in Wortham ward and the Bungalows. We noted that the corridors on Wortham ward were narrow and it would not be easy to navigate a wheelchair around the ward.

Staff did not always make information accessible to patients. We saw a range of posters displayed on Nightingale and Wortham wards about patients' rights, their physical and mental health and activities available. However, we found no information on the wards that met the Accessible Information Standard, for example, large print or easy read reading material.

Staff were able to cater to the needs of patients whose first language was not English. Although they did not have direct access to translated documents, staff showed us examples where they had translated information such as patient's rights into other languages. When needed, staff arranged for an interpreter for patients who did not speak English and the staff team included people that spoke a range of languages fluently.

Staff offered patients a range of culturally appropriate food. Menus included Kosher, Halal and vegetarian options but did not always include vegan options. Those patients who were able to cater for themselves were able to purchase their own food.

Patients could access spiritual support. The hospital had a dedicated pastoral care team who represented Christian and Muslim faiths. Staff could arrange for patients to attend religious meetings outside the hospital if they wished.

Listening to and learning from concerns and complaints

Most patients and family members we spoke with knew how to complain to the provider. Of those who had made a complaint, most agreed that staff had been responsive and had resolved their concern.

Patients received feedback from their complaint. Staff kept records of formal complaints in a log book kept on the ward. Staff could register the complaint and senior staff would address the problem with the patient. In most cases we saw that patients had signed the book with the staff member to say they felt they had resolved their concern. Staff external to the ward audited this book regularly and followed up any further problems.

Between 25 January 2019 and 31 October 2019 there were eight complaints across the service. There were three complaints on Nightingale ward, two of which were partially upheld and one not upheld; two complaints on Bungalow 65, one of which was upheld and one partially upheld; one on Fairview ward which was partially upheld; one on Swift House which was not upheld; and one on Wortham ward which was partially upheld. None of these complaints was referred to the ombudsman.

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

Requires improvement

Leadership

Leaders did not demonstrate a consistently good understanding of how to manage their services and monitor the performance of their staff teams. However, they were able to speak knowledgeably about the type of patients they cared for and how their teams worked together.

All staff said that ward managers and the senior management team were visible and approachable. Members of the senior management team visited the wards.

Managers had access to internal development opportunities and training. The service had developed some of the ward managers as junior staff and we saw evidence that managers were working to develop staff below them.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Vision and strategy

Not all staff could not consistently explain the wards' visions and values. Staff on Wortham and Nightingale were aware of recent updates to the visions and values. However, we found some staff on the Bungalows were not aware of them.

The service had communicated the new vision and strategy through the staff intranet and emails, and those staff who were aware of them were able to explain how they worked towards them in their day to day work.

Staff had not been involved in the development of the vision and strategy. Whilst the wards had local visions and values developed by the consultants, the hospital and wider provider values had not been developed in collaboration with staff on the rehabilitation wards.

Culture

Staff felt respected and supported and said they felt proud to work for the provider. Several staff we spoke with had worked at the hospital for over 10 years and several others had progressed from junior staff roles.

All staff felt comfortable raising concerns without fear of retribution. The provider had a whistleblowing line which they advertised on posters in staff offices.

Managers dealt with poor staff performance when needed. We reviewed records where managers had supported staff to improve their performance or their sickness.

Teams worked well together, if there were any difficulties, managers dealt with them appropriately.

Staff appraisals included conversations about career development. We saw examples of appraisals where staff were receiving additional training or had goals set around developing their leadership and management skills.

Staff were not aware of the work the provider was doing to promote equality and diversity in its day to day work. Staff awareness of the provider's diversity networks was low, and none questioned were members. Managers were not able to give examples of work the provider was doing to promote equality and diversity.

Managers ensured that staff received physical and emotional support. We found examples where staff were injured or distressed at work and managers had provided support and referred them to the occupational health service.

The provider recognised staff success through their star awards programme. This award programme was a nationally recognised project. Several staff we spoke with wore nominee lanyards to identify their achievement.

Governance

The provider's governance systems were not sufficiently robust to ensure that essential learning and information passed between the hospital's senior management team and the rehabilitation nursing team. Staff across all wards were unable to give examples of recent lessons learned.

On the Bungalows and Wortham ward, we found staff were not correctly completing forms for monitoring three patients on clozapine to ensure patients' physical health was not deteriorating because of the medicines they were taking. One patient had an acute condition which their medicines may have caused but staff had not identified this, monitored the condition well or escalated concerns. The patient was subsequently admitted to hospital for this condition.

Staff had not implemented internal safety projects such as reducing restrictive practice, and were not always aware of changes which the wards had made because of incidents. We found blanket restrictions on Wortham and Nightingale wards in relation to restricting access outside and restricting access to bedrooms at certain times.

Managers were not aware of shortfalls in staff training numbers. Senior managers had calculated overall training rates for the hospital and had failed to identify that the rehabilitation wards had lower compliance rates than their targets. They had therefore not taken action to remedy this.

Managers did not ensure that they recorded team meetings appropriately. We reviewed meeting minutes for staff team meetings and found they were sparse and poorly recorded. Staff returning from long term leave would not have been involved in these meetings and would not be able to use minutes to catch up.

Staff participated in local clinical audits including infection control, safeguarding, clinical supervision and implementation of outcome tools. Staff usually acted on

outcomes from these audits, however managers raised concerns that doctors did not always act on issues raised in audits and there was no clear line of communication to address the problem.

Staff understood arrangements for working with teams external to their ward and the hospital. Staff included external care providers at review meetings when appropriate and staff had contacts lists for local authority safeguarding teams.

Management of risk, issues and performance

Staff and ward managers' concerns did not always match those on the risk register. The hospital had an overall risk register but not a ward level risk register. Staff could raise concerns with ward managers. Ward managers knew how to raise concerns with senior management teams but told us they could not access or add to the risk register. Two of the three managers interviewed had not seen the hospital risk register; one was keeping their own records of some basic risks.

Staff did not have up-to-date plans for emergencies. Each patient had an individualised plan for emergency evacuation. However, we found that all plans on Wortham ward were out of date, but staff told us that nothing had changed since the last review. Managers assured us that they had completed business continuity plans, but we were unable to verify this as staff did not submit these.

While the provider did not accept all referrals to the service, nursing staff told us that they sometimes felt pressure from the senior management team to admit patients who were not suitable for the wards, for example if the patient's risks would be difficult to manage in the ward environment.

Information management

Ward managers were not using data, acting autonomously to improve their ward area's performance and quality. Senior managers had not made ward managers aware of the key performance indicators they should achieve. Ward managers had access to an online dashboard which showed how their ward was performing against other wards in clinical audits, but they did not use this information at a ward level. The information on this dashboard was timely and accurate, but not used.

Staff had access to all the equipment and technology they needed to care for people and information governance systems included processes on how to protect people's confidentiality.

Staff made notifications to external bodies such as the Care Quality Commission, the police and local authorities when needed.

Engagement

Managers engaged well with the staff team. The senior management team released information to staff about the work the hospital was doing through bulletins. Staff could raise concerns and ideas for improvements through staff forums, and managers kept minutes of these meetings. Staff could give examples of changes which the provider had made because of feedback they had given.

The provider engaged well with patients and their family members. Patients joined community meetings on a ward level and could attend regional patient forums. Most family members we spoke with had an opportunity to feed back to the service.

Staff received information about feedback given by patients and family members in their team meetings. However, as notes for these meetings were sparse, staff not in attendance could not receive suitable feedback.

Learning, continuous improvement and innovation

The provider did not encourage staff on a ward level to consider opportunities for improvement and innovation. Senior staff in the ward teams such as consultants and some ward managers were able to give examples of innovative projects they had been involved in. However, nurses and healthcare support workers were unable to give examples of projects they had been involved in or changes that had been made after incidents or complaints.

Psychology staff were undertaking a project to improve patients' motivation to engage in their care. This included strategies of reviewing audits in place, training staff in motivational technique, setting goals, reviewing risk and implementing recovery stories.

The provider was currently designing an audit to implement new outcome measures and to use them to measure patient progress.

Staff were not involved in any nationally recognised clinical research projects.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

The wards were working towards obtaining nationally recognised accreditation. The service had applied for the Royal College of Psychiatrist's accreditation for Acute Inpatient Mental Health Services (AIMS).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all emergency equipment is properly stored, maintained and easily available [Regulation 12 (2) (e) and Regulation 15 (1) (a) (e) (f) (2)].
- The provider must ensure best practice in relation to the safe storage, audit and administration of medication, in line with guidance, across all wards [Regulation 12 (2) (g)].
- The provider must ensure the physical health of all patients is monitored effectively and consistently [Regulation 12 (1) (2) (a) (b)].
- The provider must ensure patients' records are consistently available to staff in a timely manner [Regulation 12 (1) and 17 (2) (c)].
- The provider must ensure that patients' access to room keys, bedrooms, mobile phone chargers and outdoor space are only restricted where this is required through individual risk assessment [Regulation 13 (1) (4) (b)]
- The provider must ensure staff seclude patients and record seclusion in line with the Mental Health Act Code of Practice and the provider's policy [Regulation 13 (1) (4) (b)].
- The provider must ensure that the physical environment is maintained to a high standard across the whole hospital [Regulation 15 (1) (a) (e) (2)].
- The provider must ensure all concerns raised at inspections are responded to in a timely manner [Regulation 17 (1) (2) (a)].
- The provider must ensure essential learning and information is passed between the hospital's senior management team and the ward managers and that this is shared with all staff and recorded appropriately [Regulation 17 (1) (2) (a) (d) (ii) (e) (f)].
- The provider must ensure that when audits are completed across all wards, staff take action to address the issues they identify [Regulation 17 (2) (a) (b)].
- The provider must ensure staff across the hospital complete and are up to date with mandatory training [Regulation 18 (2) (a)].

Action the provider SHOULD take to improve

- The provider should consider the layout of all wards in relation national guidance. Patients had to share bathroom and shower facilities.
- The provider should ensure patients' possessions on the ward are stored safely.
- The provider should review the system for recording community meetings to enable adequate monitoring of actions raised at previous meetings.
- The provider should ensure staff reflect the patients' views and concerns in care plans completed in the forensic service.
- The provider should ensure that managers across all services can escalate concerns to the hospital risk register.
- The provider should ensure staff across all services take breaks appropriately and that arrangements for breaks do not result in understaffing.
- The provider should ensure that nutritionally balanced vegan meals are offered to patients through ward menus.
- The provider should ensure that rehabilitation ward environments are therapeutic and that efforts are made to eliminate or reduce noise from radios and doorbells.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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 (RA) Regulations 2014 Premises and equipment

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 (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	