Norfolk and Suffolk NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMY 02	Julian Hospital	Reed Ward	NR2 3TD

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

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

As this was a focussed inspection to one ward, in response to the concerns identified by a member of the public, we did not rate this core service.

However, the trust needs to address the following areas of concern:

- There was no dedicated ward manager for this ward. This post was shared with an adjacent ward. We found a lack of direction on the ward.
- There was no formal system to ensure that each individual patient's welfare was checked and reviewed at regular intervals throughout the day. Individual care plans were in place but these had not been updated in some cases to reflect increased risks to patients and staff.
- Some care records reviewed included incorrect or contradictory information. For example relating to the physical healthcare needs of patients.
- There was no current dependency tool used to establish staffing levels. We found that adequate numbers of staff were not deployed to meet the needs of the patients on this ward.
- The ward layout did not protect patient's privacy, dignity and safety to meet the Department of Health guidance in relation to the arrangements for eliminating mixed sex. We found that one female patient had to use the communal bathroom as her en-suite facility was out of order. This had been reported by front line staff but was awaiting repair.
- Staff reported problems with en-suite showers. Some were not working properly. Frontline staff confirmed that these issues had been reported to the trust's maintenance department. However, these maintenance concerns had not been addressed.
- Concerns identified by us during this inspection had not been identified or addressed by the trust's own governance processes. There was no coherent and consistent ward based response when local concerns and complaints were raised.
- Staff morale was low and some staff said that middle managers ignored their concerns.

However:

- Frontline staff were working hard to deliver care and support to patients, who often presented with behaviours that could be challenging, without effective direction from senior staff.
- Medication records were well kept and we noted the low level of use of antipsychotic medication. Documentation for the administration of covert medicines was up to date.

Summary of findings

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

Are services safe?

The trust needs to address the following areas of concern:

- Parts of the ward were visibly unclean and this included bedrooms, en-suite toilets and communal corridors. This was bought to the immediate attention of ward staff and management.
- There was cosmetic damage to the walls, floor and skirting boards within the communal lounge and corridors. Frontline staff confirmed that this had been reported to the trust's maintenance department.
- One female patient had to use the communal bathroom as her en-suite facility was out of order. This had been reported by front line staff but was awaiting repair. This had led to a trust breach of the Department of Health guidelines on gender segregation because the patient had to walk past bedrooms occupied by male patients to use the bathroom.
- Staff reported problems with en-suite showers. Some were not working properly. Frontline staff confirmed that these issues had been reported to the trust's maintenance department. However, these maintenance concerns had not been addressed.
- There was not enough staff deployed to meet the current dependency levels of the patients on the ward. Staff confirmed that there was no current dependency tool used to establish staffing levels.
- While the ward had protected mealtimes so staff could assist patients with eating and drinking. The afternoon handover took place at lunchtime so not all staff were available to support patients with their nutritional needs.

However:

- Staff had access to protective personal equipment, such as gloves and aprons.
- Staff knew how to report safeguarding concerns and liaised with the trust leads. intranet site to gain information or report issues directly to the safeguarding leads.
- Medication records were well kept and we noted the low level of use of antipsychotic medication. Documentation for the administration of covert medicines was up to date.

Are services effective?

The trust needs to address the following areas of concern:

Summary of findings

- We had difficulties accessing patients' records on the trust electronic record system despite having the support of frontline staff. Staff told us of their frustrations with the systems impacting on their work. For example, at times they were unable to locate important information relating to patient care and treatment.
- Care plans did not include continence management information for staff. This meant that front line staff did not receive clear guidance on how to support patients with their continence needs. Some care plans had not been updated to reflect increased safety risks such as recent falls.
- Some care records reviewed included incorrect or contradictory information. For example relating to the physical healthcare needs of patients.
- The records of enhanced observation levels for patients were confusing and lacked consistency. For example, some patients were reported as requiring enhanced observation but did not appear to be receiving this. Patients who required support with eating and drinking were not receiving this on a consistent basis.
- The ward did not use a formal system to ensure that each individual patient's welfare was checked and reviewed at regular intervals throughout the day.

However:

- Multidisciplinary team (MDT) meetings and staff handovers provided opportunities to review and assess patient care and individual need assessments.
- Frontline staff were working hard to deliver care and support to patients, who often presented with behaviours that could be challenging, without effective direction from senior staff.
- Senior staff reported effective working relationships with community older patients' teams and with the local NHS acute trust.

Are services caring?
We did not inspect this domain during this focussed inspection.

Are services responsive to people's needs?
We did not inspect this domain during this focussed inspection.

Are services well-led?
The trust needs to address the following areas of concern:

- There was no dedicated ward manager for this ward. This post was shared with an adjacent ward. We found a lack of direction

on the ward. Some staff seemed to be unsure of their roles and duties. There was a lack of clear direction and whilst there were trust systems in place these appeared to be disregarded at times. For example, the trust's observation policy.

- Concerns identified during this inspection had not been identified or addressed by the trust's own governance processes.
- Staff morale was low and some staff said that middle managers ignored their concerns.
- We saw some examples of the trust being open and transparent with carers and patients when things went wrong. However, there was no coherent and consistent ward based response when local concerns and complaints were identified by carers.

However:

- Staff received direct feedback from the trust via emails with key updates and information. Systems to ensure staff were kept informed, such as identifying the top ten policies for staff to read, were in place.
- The ward had a local risk register to capture risks related to their service.
- There was a low number of formal complaints received by the trust for this ward.

Summary of findings

Information about the service

Norfolk and Suffolk NHS Foundation Trust provided care on Reed ward to 13 patients who were living with dementia.

Patients were admitted to this ward for continuing care and assessment of their dementia.

There were 13 patients on the ward during our inspection. Eight patients were detained under Section 3 of the Mental Health Act. Five patients were subject to Deprivation of Liberty Safeguards.

This core service was last inspected as part of the Commission's comprehensive inspection of the trust between 13 and 21 July 2016.

The trust received an overall rating of requires improvement for this core service with safe being rated as inadequate, effective, responsive and well led as requires improvement, and caring as good.

Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were identified for this core service at that inspection. These related to:-

Regulation 10 – dignity and respect

Regulation 12 - safe care and treatment

Regulation 17 – good governance

Regulation 18 – staffing.

This inspection identified ongoing non- compliance with these regulations on this ward.

The trust had sent the Care Quality Commission their action plan to address these issues.

A comprehensive inspection of the trust to follow up on these findings was scheduled for July 2017.

Our inspection team

The team that inspected this core service were two CQC inspection managers, one Mental Health Act Reviewer and one inspector.

Why we carried out this inspection

We inspected this ward in response to concerns identified by a member of the public to the Care Quality Commission.

How we carried out this inspection

We carried out this inspection using the unannounced focussed inspection framework. This inspection focused on three domains, safe, effective and caring. Ratings are not given for this type of inspection.

During the inspection visit, the inspection team:

- reviewed the quality of the ward environment and observed how staff were caring for patients
- met with four patients who was using the service
- spoke with three family carers
- interviewed the manager for this and the adjacent ward
- met with eight other staff members; including nurses and health care assistants
- interviewed three managers with responsibility for these services

Summary of findings

- observed direct and indirect care provision to patients
- attended a handover between the early and late nursing shift teams
- examined three care and treatment records of patients
- reviewed trust incident reports
- carried out a specific check of the medication management on all 13 patients
- Reviewed in detail a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We were unable to speak in detail with any patients due to the extent and severity of their illness.

We met with three family carers. Two of whom were generally satisfied about the care and support that their relative was receiving. They told us that staff were supportive and involved them in the care being provided. They confirmed that they were kept informed about their relative's physical health care needs.

They said that staff recognised the challenges they faced as carers and gave them information and support. They said would value additional information about how to find a care home for their relative. Whilst they felt able to raise any concerns; they were unsure about the trust's complaints process.

Another carer spoken to was unhappy with the care and treatment being provided to their relative. They were dissatisfied with the trust's response to their individual complaints. Family meetings had been held with senior trust managers to try and resolve these concerns. The Commission asked the trust to be kept informed in this matter

Two carers had concerns about the arrangements in place for the laundering of clothes and one carer said that their relative was sometimes dressed in clothes that weren't their own.

These concerns were bought to the attention of senior trust managers.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that there are effective management arrangements at ward level.
- The trust must ensure that the ward protects patients' privacy and dignity and complies with the Department of Health guidance to eliminate mixed sex wards.
- The trust must ensure that location based systems are in place to respond promptly to local concerns and complaints once identified.
- The trust must ensure that hospital wide governance systems are embedded at all levels so that any risks or potential concerns are identified and mitigated promptly.
- The trust must ensure that enhanced observations if required are implemented fully and monitored for effectiveness.
- The trust must ensure that adequate staff are deployed to meet the assessed needs of patients on this ward.
- The trust must ensure that patients who required support with eating and drinking receive this on a consistent basis.
- The trust must use a formal system to ensure that each individual patient's welfare is checked and reviewed at regular intervals throughout the day.
- The trust must ensure that care records are reviewed and amended to reflect the correct information about the health care needs of individual patients.

Summary of findings

- The trust must ensure that care plans include continence management information for staff and are also all updated to reflect increased safety risks to individual patients.
- The trust must review the timing of the afternoon handover to ensure that all staff are available to support patients with eating and drinking at lunchtime.
- The trust must review the information documented on their written handover records and ensure that all information is handed over in a clear manner.
- The trust must ensure that the identified maintenance work on this ward is addressed promptly.
- The trust must manage and mitigate the infection control risks on this ward.

Action the provider SHOULD take to improve

- The trust should ensure that their laundry arrangements are reviewed and confirmed with family carers.
- The trust should consider the use of a recognised dependency tool to set establishment staffing levels.
- The trust should consider the employment of a ward based administrator to provide administrative support.

Norfolk and Suffolk NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Reed ward	Julian Hospital

Mental Health Act responsibilities

- Latest staff training data available showed most staff had current Mental Health Act training. Further training was planned for staff.
- Staff we spoke with understood the principles of the Act.
- The trust had systems in place to ensure compliance with the Act and adherence to the guiding principles of the code of practice.
- Systems were in place to provide information to staff about the use of the Act.
- Medical staff completed consent to treatment with patients and or their main carer.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Latest training information showed most staff had completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- Staff we spoke with understood the principles of the Act.
- Independent mental capacity advocates (IMCA) were available to support patients who lacked capacity, as needed.
- Medical staff completed capacity forms with patients and / or their main carer.
- We found examples of consistent recording of do not resuscitate decisions for patients. These had been discussed with family carers where the patient lacked capacity.

Are services safe?

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

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

Our findings

Safe and clean environment

- Parts of the ward were visibly unclean and this included bedrooms, en-suite toilets and communal corridors. This was bought to the immediate attention of ward staff and senior managers.
- There was a dedicated cleaner on the ward. However, they weren't present at the beginning of our inspection. A list of cleaning duties was seen but the monitoring arrangements of the effectiveness of these were unclear.
- The trust had carried out an infection prevention and control review of the main building including this ward on 21 April 2017. Concerns had been identified during this review. For example, waste disposal bins across the hospital were not clean. Control measures had yet to be fully implemented by the trust.
- The layouts allowed staff to observe most parts of the buildings. However, there were some blind spots, where staff might not easily observe patients. This risk was reportedly managed by staff's direct observation of patients deemed to be at risk of falling.
- There was cosmetic damage to the walls, floor and skirting boards within the communal lounge and corridors. Staff reported problems with en-suite showers. One was out of order and others were not working properly. Frontline staff confirmed that these issues had been reported to the trust's maintenance department. However, these maintenance concerns had not been addressed promptly.
- The ward did not have any grouped designated male and female bedroom areas due to the ward layout.We found that one female patient had to use the communal bathroom as her en-suite facility was out of order. This had been reported by front line staff but was awaiting repair. This had led to a trust breach of the Department of Health guidelines on gender segregation. This was because this patient had to walk past bedrooms occupied by male patients to use the communal bathroom.
- Frontline staff said they mitigated most risks to patients through the use of bedroom sensors, self-closing doors, staff observations and using rooms near the nursing office for patients assessed as needing a higher level of care.
- The trust had completed environmental risk assessments for the premises and updated them regularly. There were numerous ligature points within the ward, particularly in bathrooms. These included, for example, grab rails, taps and door closures. Potential risks had been mitigated by the trust by assessing patients prior to admission and the use of supportive observation.
- Patients and carers had a secure central courtyard garden to access fresh air.
- There were call bells throughout the ward for patients to use to get help if needed. Staff carried personal alarms to summon other staff in an emergency.
- Staff had access to protective personal equipment, such as gloves and aprons.

Safe staffing

- There was seven staff on the early shift, eight staff on the evening shift and seven staff on duty at night. Day time staffing levels included two registered nurses. The shortage of permanent staff meant that two bank health care assistants from NHS professionals covered the early and afternoon shifts respectively. Five of the six healthcare assistants working the night shift were from NHS Professionals. One qualified nurse was off sick in the morning and had been replaced by a bank health care assistant. Managers informed us that a healthcare assistant was working a twilight shift to manage the increased workload at that time of day. The trust displayed their safer staffing ward information on a noticeboard near the entrance to the ward but this had not been updated to reflect the current staffing levels.
- There was not enough staff deployed to meet the assessed needs of patients on this ward. The records seen showed us that three patients were on enhanced observations of 1:1. This meant that four staff were

Are services safe?

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

required to care for the nine other patients. Frontline staff also confirmed that there were not enough staff on duty to meet the current dependency levels of the patients on the ward.

- Senior staff confirmed that there was no current dependency tool used to establish staffing levels.
- We found that there was no ward based administrator to offer administrative support to front line clinicians. We found that frontline staff were not always clear about the trust's administrative procedures.
- An electronic staff trust rostering system was in place.

Assessing and managing risk to patients and staff

- There were no patients that had recently been secluded or held in long term segregation.
- Some care records reviewed included incorrect or contradictory information. For example relating to the physical healthcare needs of patients.
- Some care plans had not been updated to reflect increased safety risks such as recent falls.
- Staff received prevention and management of violence and aggression training. Staff told us they were working towards reducing the use of restraint and focussing more on de-escalation as recommended in best practice guidelines.
- Staff reported having to use restraint to enable personal care to be completed in some instances. This was recorded in patients' care plans.
- Staff used a situation, background, assessment, recommendation (SBAR) tool during handovers, which was a structured method for communicating critical information that required immediate attention and action. However, we found that some information was incomplete and incorrect in the written records kept and not all information was handed over in a clear manner.
- Staff knew how to report safeguarding concerns and liaised with the trust leads. intranet site to gain information or report issues directly to the safeguarding leads.
- Medication records were well kept and we noted the low level of use of antipsychotic medication. Documentation for the administration of covert medicines was up to date.
- Staff had access to information about 'slips, trips and falls' and pressure ulcers. Staff had completed fall and skin integrity assessments to identify and reduce the risk. Aids and adaptions such as bedroom sensors, hip protectors and fall mats were used for patients assessed as being at high risk of falls.
- We saw that one floor mat was placed against the wall when not in use during the day and this presented a potential risk to patients and staff.
- While the ward had protected mealtimes so staff could assist patients with eating and drinking the afternoon handover took place at lunchtime so not all staff were available to support patients with eating and drinking.
- Staff monitored patients' food and drink intake and this was recorded. However, we noted gaps in some of those records kept.

Reporting incidents and learning from when things go wrong

- There had been two incidents of un-witnessed falls recorded in those records inspected. Other records showed that these patients were on enhanced observations at the time. The trust subsequently took urgent action to review these incidents.
- Staff knew how to use the trust incident reporting system. We saw examples of reported incidents such as those relating to falls and assaults on staff.
- Managers had access to governance systems to identify themes from incidents and compare their ward performance to others. For example the number of incidents including violence and aggression and patient harm.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- We had difficulties accessing patients' records on the trust electronic record system despite having the support of frontline staff. Staff told us of their frustrations with the system and how this negatively impacted on their work. For example, at times they were unable to locate important information relating to patient care and treatment.
- Access to the trust's incident reporting records was slow and the system was difficult to navigate.
- Care plans did not include continence management information for staff. This meant that front line staff did not receive clear guidance on how to support patients with their continence needs.
- Some care records viewed held incorrect or contradictory information about the patient.
- Medical staff had completed a physical healthcare check on admission. A range of physical healthcare assessment tools, such as the Waterlow scale (a tool used to estimate the risk of a patient developing a pressure sore) and the malnutrition universal screening tool used to assess nutritional risks were being used.

Best practice in treatment and care

- The records of enhanced observation levels for patients were confusing and lacked consistency. For example, some patients were reported as requiring enhanced observation but did not appear to be receiving this.
- Patients who required support with eating and drinking were not receiving this on a consistent basis.
- The ward did not use a formal system to ensure that each individual patient's welfare was checked and reviewed at regular intervals throughout the day.
- Some physical healthcare monitoring of patients took place. Staff referred to completing physiological workbook training. The trust audited compliance with physical healthcare checks on admission and annual health checks.
- Staff used nationally recognised assessment tools such as the modified early warning score a rating scale for staff to document physical observations of patients and a risk assessment and management system.
- Staff used communication aids such as pictorial cards and ward signage to promote orientation where possible.
- Frontline staff were working hard to deliver care and support to patients, who often presented with behaviours that could be challenging, without effective direction from senior staff.

Skilled staff to deliver care

- The ward team consisted of nurses, health care assistants, occupational therapist and medical staff.
- Gaps in permanent staffing were covered by temporary bank staff supplied by NHS professionals.
- Nursing staff competency checks for administration of medication were in place.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team (MDT) meetings and staff handovers provided opportunities to review and assess patient care and individual need assessments.
- Senior staff said there were effective working relationships with community older patients' teams and with the local NHS acute trust.

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

- Latest staff training data available showed most staff had current Mental Health Act training. Further training was planned for staff.
- The trust had systems in place to ensure compliance with the Act and adherence to the guiding principles of the code of practice.
- Systems were in place to provide information to staff about the use of the Act.
- Staff we spoke with understood the principles of the Act.
- Staff had access to the MHA administrators for administrative support and legal advice.

Are services effective?

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

- Staff explained patients' legal status and rights under Section 132 of the MHA on admission. However this was not repeated on a regular basis.
- Patients had access to independent mental health advocates (IMHA). Wards displayed posters showing contact details.
- Ward entrances were locked with entry and exit controlled by staff. There were signs displayed on the doors providing information on their right to leave for informal patients.
- Medical staff completed consent to treatment and capacity forms, Staff attached copies to medication charts to ensure nurses administered medication in accordance with the Act.

Good practice in applying the Mental Capacity Act

- Latest training information showed most staff had completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- Staff we spoke with understood the principles of the Act.
- Independent mental capacity advocates (IMCA) were available to support patients who lacked capacity, as needed.
- We found examples of consistent recording of do not resuscitate decisions for patients. These had been discussed with family carers where the patient lacked capacity.

Are services caring?

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

Our findings

We did not inspect this domain during this focussed inspection.

Are services responsive to people's needs?

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

Our findings

We did not inspect this domain during this focussed inspection.

Are services well-led?

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

Our findings

Vision and values

- Information was displayed on the ward about the trust's visions and values.
- Information about senior trust executives was displayed on the unit.
- Managers confirmed that values based recruitment was taking place to try and ensure that staff recruited could uphold these values.

Good governance

- Locality middle managers appeared to be detached from this ward. For example, frontline staff reported a lack of support from middle management.
- Concerns found during this inspection had not been identified or addressed by the trust's own governance processes.
- The ward had a local risk register to capture risks related to their service.
- Staff received direct feedback from the trust via emails with key updates and information. Systems to ensure staff were kept informed, such as identifying the top ten policies for staff to read, were in place.

Leadership, morale and staff engagement

- There was no dedicated ward manager for this ward. This post was shared with an adjacent ward. Senior trust managers informed us that the post was due to be filled by the middle of June.
- We found a lack of direction on the ward. Some staff seemed to be unsure of their roles and duties. There was a lack of clear direction and whilst there were trust systems in place these appeared to be disregarded at times. For example staff did not adhere to the trust's observation policies
- Staff morale was low and some staff said that middle managers ignored their concerns.
- We saw some examples of the trust being open and transparent with carers and patients when things went wrong. However, there was no coherent and consistent ward based response when local concerns were identified by carers and their advocates.
- There was a low number of formal complaints received by the trust for this ward.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury **The trust did not ensure that patients received safe care and treatment** This was because: • Some patients were reported as requiring enhanced observation but were not receiving this. • The trust did not use a formal system to ensure that each individual patient's welfare was checked and reviewed at regular intervals throughout the day. • Care plans did not include continence management information for staff. • Some care plans had not been updated to reflect increased safety risks such as recent falls. • Some care records included incorrect or contradictory information • Some information was incorrect and incomplete in the written handover records kept and not all information was handed over in a clear manner. • This was a breach of regulation 12 (1) (2)

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Assessment or medical treatment for persons detained under the Mental Health Act 1983.

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

The trust did not ensure that the ward protected patients' privacy and dignity and complied with The Department of Health guidance and Mental Health Act 1983 Code of Practice to eliminate mixed sex wards.

This was because:

- One female patient had to use the communal bathroom as her en-suite facility was out of order. This had led to a trust breach of the Department of Health guidelines on gender segregation.
- This was a breach of regulation 10

Regulated activity

Regulation

Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

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

Treatment of disease, disorder or injury

The trust did not ensure that the nutritional and hydration needs of patients were consistently met

This was because:

- Patients who required support with eating and drinking were not receiving this on a consistent basis.
- The afternoon handover took place at lunchtime so not all staff were available to support patients with their nutritional needs.
- This was a breach of regulation 14 (1)

Regulated activity

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

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

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

The trust did not ensure that their premises were clean and well maintained.

This was because:

- Infection control risks were not managed or mitigated effectively. Parts of the ward were unclean and damage to the ward environment had not been addressed.
- Some en-suite showers were out of order or not working properly.
- This was a breach of regulation 15 (1).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983.	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Treatment of disease, disorder or injury

The trust did not ensure that the ward was adequately staffed.

This was because:

- Adequate staff were not deployed to meet the assessed needs of the patients on this ward.
- This was a breach of Regulation 18(1) (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Treatment of disease, disorder or injury

This section is primarily information for the provider

Requirement notices

The trust did not ensure that robust governance structures were in place.

This was because:

- There was no coherent and consistent location based response when local concerns and complaints were identified by carers or staff.
- Concerns found during this inspection had not been identified or addressed by the trust's own governance processes.
- This was a breach of Regulation 17.