Mildmay Oaks

Quality Report

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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?	Requires improvement
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.

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

Overall summary

We rated Mildmay Oaks Independent Hospital as requires improvement because:

- Agency staff were not trained to the standard set out in the staff training policy. We did not know how many agency staff this affected because the training records were not up to date.
- Staff did not receive training which met patients' needs.
- Staff were not receiving regular supervision and support.
- Patients on Winchfield ward were not protected from the risk of adverse side effects from medicines that were administered as the provider was not following its own protocol or national guidance post use of rapid tranquilisation.
- Patients on Winchfield ward were not protected from the risks associated with blind spots which were not mitigated.
- Ligature risk assessment management plans were generic and not detailed.
- The clinic room on Winchfield ward was not well maintained and not all emergency equipment and medication was available.
- The provider did not have a clear overview of the frequency of prone restraints.
- Patients' property in the store room on Winchfield ward was not kept safe or looked after by staff.

However:

- Ward managers were able to adjust staffing levels when necessary to ensure patient safety and meet their needs appropriately.
- Patients had access to a range of psychological therapies. Therapies offered to patients were delivered on a one-to-one and group basis depending upon the needs of the patient.
- Patients were treated kindly by staff and felt involved in their care.
- The facilities promoted recovery, comfort and dignity and there was a good range of activities on and off the wards.
- Staff morale across the hospital was good and staff felt supported by the senior team.
- Learning from incidents was shared with staff. Incidents were discussed at clinical governance and health and safety meetings and the learning was shared with staff teams.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Requires improvement	

Summary of findings

Contents

Requires improvement

Mildmay Oaks

Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Mildmay Oaks

Mildmay Oaks Independent Hospital is a low secure and locked rehabilitation service for men and women with learning/intellectual disability and autism spectrum disorder and mental illness.

The wards at Mildmay Oaks are:

Winchfield Ward - 18 bed male low secure

Mattingley Ward - 8 bed male low secure

Heckfield Ward - 8 bed female locked rehabilitation

Bramshill Ward - 5 bed male locked rehabilitation

Eversley Ward - 8 bed male locked rehabilitation

Mildmay Oaks is registered to provide the following 'regulated activities':

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

There is a registered manager in post at this location.

This location was last inspected in May 2017 and had the following requirement notices:

Regulation 18 HSCA (RA) Regulations 2014 Staffing. At our previous inspection we found there were not enough appropriately qualified professionals. This remains a concern and therefore the requirement notice remains in place.

Regulation 9 HSCA (RA) Regulations 2014 Person-centred

Care. At our previous inspection, we found care plans were not recovery focussed and did not reflect the needs of the patient in an accessible format. This area has been addressed.

Regulation 11 HSCA (RA) Regulations 2014 Need for

Consent. At our previous inspection, we found the provider was not appropriately assessing patients' capacity. This area has been addressed.

Regulation 12 HSCA (RA) Regulations 2014 Safe care and

Treatment. The provider did not ensure staff transferred all relevant information held on the electronic patient to paper records they used. This area has been addressed.

Additional requirement notices have been served following the inspection in May 2018.

Our inspection team

The team was comprised: two CQC inspection managers, three CQC inspectors, one national professional advisor for CQC who is a learning disabilities specialist, two specialist advisors and one expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example, as a carer.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of this inspection

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

Before the inspection visit, we reviewed information that we held about the service and we asked a range of other organisations such as the Clinical Commissioning Groups and NHS England to share information with us about the provider.

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 21 patients who were using the service;
- spoke with the managers or acting managers for each of the wards;
- spoke with 19 other staff members; including doctors, nurses, occupational therapist, psychologist, the Mental Health Act administrator, human resources manager and a social worker;
- received feedback about the service from three care co-ordinators or commissioners;
- spoke with the hospital police liaison officer:
- attended and observed one hand-over meeting and one ward community meeting;
- looked at 13 care records of patients:
- carried out a specific check of the medication management on all five 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 21 patients that were using the service and 3 carers of patients using the service. Patients and carers' views on the service were mixed.

Patients we spoke with told us they liked the staff, the care was good and they felt looked after. Patients told us they felt involved in their care and were given copies of their care plans. We were also told by patients they could personalise their bedrooms the way they wanted to.

However, patients on Winchfield ward said they felt the food was cold and portion sizes were small. They also said they did not like the ward environment as it was too noisy.

All three carers that we spoke with felt the care was good. One carer felt the communication was excellent, however, the other two carers felt they were not always communicated with.

Two carers felt there enough activities on the wards, however, one carer felt there were not enough.

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?

Requires improvement 

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

- There were a number of blind spots across the hospital. The provider had ordered convex mirrors to provide better visibility of some blind spots but there were no time scales around when they would arrive and when they would be fitted.
- The ligature risk assessments were generic and not sufficient. The management of the ligatures in the risk assessment was not detailed or thorough enough. New ligatures on Bramshill ward had not been added to the ligature risk assessment. The provider addressed this at the time of our inspection.
- Staff did not regularly assess whether the clinic room on Winchfield ward was stocked appropriately. The clinic room was missing emergency equipment and necessary medication.
- On Eversley ward, a patient had experienced several seizures although there was no formal diagnosis of epilepsy we found there was no bath protocol in place.
- Staff were not following infection control principles on Bramshill ward. Staff were filling the red soiled water bucket in the communal bath, cleaning it out with a kettle in the kitchen and disposing of the soiled water in the communal toilets.
- There was a high staff vacancy rate across the hospital. Staffing vacancies were 89.1%, most shifts were being filled by locum agency staff. Out of 40 nurses working at the hospital, there was one permanent, two bank and one locum registered learning disability nurses. The remaining 36 nurses working at the hospital were registered in mental health and not learning disabilities.
- Staff were not up–to-date with mandatory training. The agency staff profiles were out of date which meant that the provider had no overview of which staff had completed mandatory training.
- Staff on Winchfield ward were not following post rapid tranquilisation protocol. There were four incidents of rapid tranquilisation in the month that we inspected. Staff did not complete post rapid tranquilisation physical observations on any occasion.

However:

- Ward managers were able to adjust staffing levels when necessary to ensure patient safety.

Summary of this inspection

- All wards, except Winchfield ward, had clinic rooms that were well stocked and frequently checked.
- Cleaning records were up to date across all wards.
- Staff responded to emergency alarms appropriately.
- Despite the high use of agency staff, staffing ratios were good and met patients' needs.
- Staff completed and reviewed risk assessments for all patients.
- Learning from incidents was shared with staff. Incidents were discussed at clinical governance and health and safety meetings and the learning was shared with staff teams.

Are services effective?

Requires improvement

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

- Not all staff received supervision. On Mattingley ward, only seven of 15 staff had received supervision. This meant there was a risk that staff were not receiving appropriate support and supervision in delivering effective care and treatment.
- We were not assured that agency staff had received training in either the Mental Health Act or Mental Capacity Act because their training records did not evidence this.
- Not all staff received an orientation to the ward. The agency profiles we reviewed did not all have orientations in them.
- Staff did not assess the capacity of patient's' prescribed non-psychotropic medication. This was not in line with the Mental Capacity Act.
- There was a lack of registered nurses experienced and skilled in working with patients with a learning disability. We were not assured that staff were appropriately trained in providing care that met the needs of the people using the service.

However:

- Patients' care plans were personalised and regularly reviewed.
- Patients had access to a range of psychological therapies. Therapies offered to patients were delivered on a one-to-one and group basis depending upon the needs of the patient.
- The physical health nurse coordinated all the physical health needs of the patients and liaised with the GP.
- There was a full multidisciplinary team. This included consultant psychiatrists, clinical and forensic psychologists, occupational therapists, a social worker, a speech and language therapist, nurses, healthcare assistants and therapy assistants.
- Patients were supported to make decisions and where they lacked capacity, staff supported them by holding best interest meetings.

Summary of this inspection

Are services caring?

Good

We rated caring as **good** because:

- Patients were being treated kindly by staff. Staff knew the patients well and the patients said they liked them.
- Patients felt involved in their care. Patients had copies of their care plans and knew what was in them. Patients attended the restrictive intervention reduction meetings to feedback their views.
- Patients' views were taken into account on the wards.There was evidence that patients' feedback was acted on by staff.

Are services responsive?

Good

We rated responsive as **good** because:

- All patients had a discharge date and a plan for discharge. Patients had discharge care plans in their care records.
- The facilities promoted recovery, comfort and dignity. There were adequate rooms available for therapies and quiet areas for patients to spend time in.
- Patients were able to personalise their bedrooms. Patients had brought in their own possessions such as: televisions; computer consoles and radios.
- There was a good range of activities available to patients. Patients enjoyed activities on and off the ward and had joined a local football league.
- Staff dealt with complaints thoroughly. There was a clear complaints process and thorough records were kept of each complaint and its outcome.
- Adjustments had been made throughout the hospital for people with disabilities. All wards had accessible information available. There was pictorial signage around the hospital. Patients' communication needs were clearly documented in their care records.

However:

- There was not sufficient outside seating. There was only outside seating on Heckfield ward, we had brought this to the attention of the provider previously after a Mental Health Act monitoring visit.
- Staff were not checking that food was at a safe temperature to be served to patients. Patients on Winchfield and Bramshill ward complained that the food was cold. Patients did not enjoy the food on these wards and said the portions were small.

Summary of this inspection

- Patients' property in the store room on Winchfield ward was not kept safe or looked after by staff. Patients' property was piled from floor to ceiling with no labelling and left loose. Some items could have been taken from the hatch on the side of the wall because staff left the items in easy reach.

Are services well-led?

Requires improvement

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

- There was no effective overview of training of agency staff. Agency staff profiles were out of date and it was unclear which staff had completed mandatory training. There was no central spread sheet that gave a clear view of training for the whole staff team.
- Staff were not supervised regularly. There was no oversight of supervision compliance; managers had different systems for where they stored supervision records. On Mattingley ward, only seven of 15 staff had received supervision.
- Sickness rates for permanent staff were high. Sickness rates for the last 12 months were 25.4%. We did not receive data about the sickness rates for the 89.1% of agency staff.

However:

- Despite the high use of agency staff there was a good ratio of staff to patients. Patients said they thought there were enough staff to meet their needs. Activities were not cancelled due to staff shortages.
- There were clear systems in place to monitor health and safety issues.
- Staff morale across the hospital was good. Staff told us they felt supported by senior people within the hospital. Staff were positive about recent changes and enjoyed working at the hospital.
- Outcomes and learning from incidents were shared with all staff. Incidents were discussed at clinical governance and health and safety meetings and the learning was shared with staff teams.

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 maintained clear records of patients' leave. The leave plan described the type of leave the patient was authorised for and the staff support required. The record showed observations made whilst the patient was on leave. If leave was denied to a patient the nurse in charge would offer a one-to-one meeting to discuss this with the patient.

The service could not clearly identify how many staff were trained in the Mental Health Act because agency staff profiles were out of date. Although the provider had assurance about the substantive staff, there was no assurance about the 89.1% of agency staff.

Staff adhered to Mental Health Act treatment requirements. We reviewed five prescription charts on Bramshill ward and eight prescription charts on Winchfield ward. All prescription charts had accompanying consent to treatment forms. The hospital requested second opinion appointed doctors as required. Treatment forms matched the prescription charts and capacity assessments were in place for patients being administered psychotropic medication. However, capacity assessments were not in place for patients that were administered non-psychotropic medication where there had been doubt about patients' capacity. This meant that patients may have lacked capacity to consent to non-psychotropic medication and were being administered it without the legal process required under the Mental Capacity Act.

Patients had their rights explained to them under the Mental Health Act. Records showed that staff explained patients' rights verbally and in writing. Patients' rights were also given in easy read format.

Staff were able to request legal advice and support from the Mental Health Act administrator based at the hospital. There was a regional Mental Health Act Manager who supported and supervised the hospital administrator.

Mental Health Act detention papers were in good order. Documentation was accurate, up to date and stored securely.

The Mental Health Act was monitored through quarterly audits. The Mental Health Act administrator was responsible for completing the audits and checked compliance against the code of practice. There was evidence that when the audit had picked up errors, appropriate actions were followed completed. For example, a recent audit identified that three patients did not have their current consent to treatment certificates with their prescription charts, this was rectified after the audit.

Patients had access to independent mental health advocates when necessary. The Independent Mental Health Advocates visited the wards weekly and met with every patient that wished to see them. There were posters on the walls of the wards advertising the advocacy service. Posters had a picture of the advocate so that patients knew who they were.

Mental Capacity Act and Deprivation of Liberty Safeguards

The service could not demonstrate how many staff were trained in the Mental Capacity Act because the agency staff profiles were out of date. Permanent staff received Mental Capacity Act training as part of their corporate induction. Staff told us they received face-to-face Mental Capacity Act training annually.

In the last six months there were three Deprivation of Liberty Safeguards applications made to the local authority. There were delays in best interest assessments from the local authority; these were being followed up by the Mental Health Act administrator. The Deprivation of Liberty Safeguards file contained the standard authorisation from the local authority. It also contained copies of letters sent to the patient explaining that their

detention had been authorised and providing information to the patient. Information was also provided about advocacy and a booklet explaining what the Deprivation of Liberty Safeguards was.

Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us that Mental Capacity assessments were usually completed in twos, often with the consultant psychiatrist and the psychology team. There was a Mental Capacity and Deprivation of Liberty Safeguards policy which staff had access to. Mental capacity assessments were decision specific. For example, there was an assessment of a patient's capacity to make decisions about their finances and a separate assessment of the patient's capacity to make decisions about where they live. Capacity assessments were clear and involved family members where necessary to support the patient to make the decision. Staff made best interest decisions with patients and their families; these were well documented in care records.

Staff used the least restrictive intervention when restraining or restricting a patient was necessary. Records showed that staff only supported patients to the floor as a last option and frequently tried to walk the patient to another area whilst holding them. Investigation records showed that when there had been incidents where staff had not used the least restrictive method, there was a full investigation and the member of staff was dealt with through disciplinary processes.

There was no local MCA lead at the hospital, the provider had a regional MCA lead who supported the site MHA administrator. However, staff in the service were unaware of this role.The Mental Health Act administrator was happy to support staff with the application of the Mental Capacity Act but felt they needed more training to do so.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

There were blind spots in a number of locations on the wards. On Winchfield ward the seclusion room had an area that staff did not have a clear view of. There was a convex mirror in place but it was not sufficient to enable staff to clearly see what the patient was doing. There was another blind spot in the high dependency lounge. The provider was aware and had ordered mirrors for the locations. However, they did not have any timescales for when they would be delivered and installed. There was no clear plan to mitigate the risks in the interim.

On Eversley ward there were two air conditioning units in the garden and a low roof making it which would have been easy for patients to gain access to the roof. We raised this with the provider at the time of our inspection. The provider told us they wold take urgent action to secure the edges of the roof with non-climb furnishings.

The ligature risk assessments were not detailed enough. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The hospital had a ligature risk assessment system in place. However, the management of the ligature risks was not in depth enough to keep patients safe. On Bramshill ward, staff had unlocked the kitchen and laundry room doors to promote patients' independence and allow them to wash their clothes and cook for themselves. Staff did not reassess the risks in those areas and we found ligatures that staff were unaware of and were not on the ligature risk assessment. We informed the provider about this at the time of our inspection and the ligatures which were not on the risk assessment were added to the list.

All wards complied with Department of Health guidance on same sex accommodation.

Most wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency medicines. Staff regularly checked emergency medicines. However, on Winchfield ward there were missing items from the emergency resuscitation bag but staff had signed that all the equipment was in place. There were emergency medicines that were out of date, missing vials of adrenaline and the weighing scales had not been calibrated for over a year and were not working accurately. This showed that staff were not monitoring the clinic room which may have put patients' safety at risk. There was also no Flumazenil available in the clinic room, when we discussed this with staff, they did not know what Flumazenil was or when they would need to use it. Flumazenil is a drug used to reverse the sedative effects of a benzodiazepine. Staff on Winchfield ward had administered benzodiazepines to patients four times that month.

The hospital had two seclusions rooms, one on Winchfield ward and one on Mattingley ward. However, the seclusion room on Mattingley ward had not been used since January 2018 and was being used as a storage space. The seclusion room on Winchfield ward provided two-way communication, was well ventilated and had washing facilities and a toilet.

All wards were clean, well decorated and had good furnishings which were comfortable.

Infection control principles were not always followed on Bramshill ward. We found a red bucket, which should only be used in the toilets, underneath the washing machine door because there was no sluice to store it in. This meant that patients had to move the bucket to wash their clothes or load and empty their washing over the red bucket. Staff told us they filled the bucket in the communal bath and emptied the soiled water down the toilet. However, there were hand sanitisers on the wards in the main staff office and signs reminding staff to wash their hands properly. We had no concerns about infection control on other wards.

Equipment was well maintained across the hospital. There was a system in place for repairs.

Cleaning records were up to date and showed that wards were regularly cleaned. All wards had been deep cleaned the week before our visit.

All staff carried alarms in wards areas. We witnessed the alarms sounding on a number of occasions and observed staff responding to alarms on other wards appropriately.

Safe staffing

The below data range is 01 December 2017 to 01 February 2018.

Establishment levels: qualified nurses (WTE) 32

Establishment levels: nursing assistants (WTE) 82.1

Number of vacancies: qualified nurses (WTE) 21

Number of vacancies: nursing assistants (WTE) 18.2

Number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in a 3 month period: 146.88

The number of shifts that were not filled by bank or agency staff where there was sickness, absence or vacancies in a three month period: 0

Staff sickness rates (%) in 12 month period: 26%

Staff turnover rate (%) in 12 month period: 11%

Staffing ratios were good. The provider reviewed staffing numbers in January 2018, increasing the number of qualified staff but not the overall number of staff on each shift. On Winchfield ward there were three nurses working during the day and 12 nursing assistants. At night there were two nurses on duty and 10 nursing assistants. These staffing numbers included staff needed to support patients on enhanced observations. On Mattingley and Eversley ward there were two nurses and two nursing assistants during the day and one nurse and two nursing assistants at night. On Heckfield ward there were two nurses and one nursing assistant during the day and one nurse and one nursing assistant at night. On Bramshill ward there was one nurse and two nursing assistants during the day and one nurse and one nursing assistant at night.

There was a high staff vacancy rate across the hospital. Staffing vacancies were 89.1%. The provider had been working on a recruitment campaign which included radio and local newspaper advertising, targeted mail drops, web based job boards and site open days.

There was a high percentage of agency staff working across the hospital. The service was using locum agency staff on long term contracts of three to six months but some of the locums had worked at the hospital over 12 months. This meant there was consistency for the patients and the staff were familiar with the hospital.

All ward managers told us that they were able to request extra staff if there were challenges on their ward. The ward manager on Eversley ward told us how staffing numbers on the ward had been reduced but following an incident and staff feeling unsafe, senior managers had increased staffing numbers again. Staff also told us that staffing numbers were reviewed as a team at daily handover meetings. On all the wards we visited staff were visible in communal areas.

Patients regularly had one-to-ones with staff. Patients told us there were enough staff to meet their needs. Staff were observed spending time with patients on a one-to-one basis and as part of groups.

Patients had regular leave from the wards. Leave records showed that patients regularly used their leave either on a group or individual basis depending upon risk assessment. Patients on most wards were engaged in activities and using their leave appropriately. Some patients were unable to use leave due to delays from the Ministry of Justice, this was out of the control of the hospital. However, staff told us that patients could only access their leave if they had tidied their room, met their personal hygiene needs and had been settled for 24 hours.

There was adequate medical cover day and night. The service had two consultant psychiatrists, one was substantive and acting as the medical director. The second

doctor was a locum. Staff told us there was never a problem accessing advice and support and doctors would attend quickly in an emergency. There was an on-call rota system in place for medical cover out of hours.

We were not assured staff were up to date with mandatory training. Out of the 27 agency personnel records we reviewed, 18 records were not up to date with mandatory training compliance. We discussed this with the human resources manager who said that agency profiles had not been updated. This was not in line with the provider's training policy in relation to agency workers. There was no system for monitoring agency training compliance. We raised this at the time of our inspection and the provider gave us assurances that they were requesting updated profiles from all agencies and were going to audit all permanent staff files.

Assessing and managing risk to patients and staff

There were four episodes of seclusion during the period 01 September – 28 February 2018. All four incidents occurred on Winchfield ward. We reviewed CCTV footage of one episode of seclusion and saw the staff guiding the patient into the seclusion room appropriately following an incident. The seclusion lasted for a short period of time and was initiated to keep the patient and other patients on the ward safe.

On Eversley ward, a patient had experienced several seizures although there was no formal diagnosis of epilepsy we found there was no bath protocol in place. Staff on Eversley ward reported they did not have training in epilepsy. We raised this with the provider at the time of our inspection. The provider gave assurances that the epilepsy policy would be implemented on the ward and the care plan and risk assessment would reflect bathing safety for this patient. We were also assured that the physical health nurse would provide epilepsy training to all staff on Eversley.

The provider did not have an effective overview of the types of restraints used on wards. There were 174 episodes of restraint on 14 patients in the same six-month period. These were highest on Winchfield ward and Eversley ward. Staff recorded any time there had been physical contact with a patient as part of an intervention. There was some confusion about the number of incidents which resulted in a prone restraint (when staff held a patient face down). The data the service provided prior to the inspection stated there had been zero prone restraints. However, we found data on site which showed there had been incidents of prone restraint. We asked the service to look into this and found that they were recording prone restraint inaccurately. Therefore, we could not be assured of the frequency of prone restraints.

We reviewed 14 care records, all were of a good standard. All records showed there was a risk assessment on admission. The service was using the Historical Clinical Risk Management-20, a recognised risk assessment tool. Records we reviewed showed that staff updated risk assessments following incidents.

The service was committed to reducing restrictive practice and blanket restrictions. Blanket restrictions are rules or policies that restrict people's liberty or other rights without carrying out individual assessments. The Mental Health Act Code of Practice says blanket restrictions should be avoided unless they are necessary and proportionate. The service had recently introduced a monthly restrictive practice meeting which had patient representation. There was evidence in daily community meeting minutes that patients were able to give feedback on reducing restrictive practice on the wards. Each ward had a reducing restrictive practice book for staff and patients to record their views and ideas.

Patients had their observation levels reviewed daily by nursing staff. Where patients were on enhanced observations, there was a communication profile for the patient with the observation record sheet to help staff monitor and engage the patient.

We reviewed two incidents of restraint on the closed-circuit television recordings. Both incidents of restraint were carried out as described on the incident reporting system.

Staff knew how to recognise and report abuse. Staff told us they received annual safeguarding training in the protection of adults and children. A designated safeguarding officer within the service delivered face-to-face training to staff, support and advice. Staff reported good working relationships with the local authority safeguarding team. There was evidence of ongoing contact with the safeguarding team about safeguarding alerts. The local safeguarding team's details were displayed in the ward offices.

Staff on Winchfield ward did not document the necessary post rapid tranquilisation physical health checks in line

with National Institute for Health and Care Excellence guidelines. Therefore, patients who had been sedated and were at increased risk of respiratory depression were not being monitored. We reviewed all the medicines charts on Winchfield ward and found that rapid tranquilisation had been administered on four occasions within the month prior to the inspection. The post rapid tranquilisation physical health check protocol was not followed on any occasion. We also found that on one occasion a patient had been given medicine they were not prescribed. We asked staff to raise this as an incident on the electronic reporting system. Medicines charts on other wards were in good order.

Staff promoted patients' independence in managing their own medication. On Bramshill ward, some rooms had lockable medication cupboards for patients to manage their own medication.

There were procedures for children to visit the service. All child visits were planned in advance. Staff supervised all visiting children in the therapy chalet which was away from the wards.

Track record on safety

There were 11 serious incidents reported in the twelve months prior to the inspection. These incidents involved; four allegations of staff assaulting patients, two allegations of patients assaulting staff, one allegation of a patient assaulting another patient, an incident where a patient climbed on the roof and caused extensive damage, loss of heating, staff sleeping on duty and an incident of deliberate self-harm. Staff were not aware of outcomes and learning from serious incidents. Serious incidents were discussed at senior staff meetings such as the health and safety meeting and clinical governance. However, we were not assured that the learning reached all staff teams.

Reporting incidents and learning from when things go wrong

Staff reported incidents on the electronic incident reporting system. All staff had access to the system and knew what to report. Ad hoc agency staff were partnered with a regular staff member (this may have included a long term agency staff member) who logged them into the system to input a report following an incident they had been involved in. The incident reporting system was also used to log environmental concerns, for example, maintenance issues or if contraband items were found in the grounds.

Incidents were categorised by the level of severity. There was a flowchart on each ward with the incident categories to aid staff members in correctly identifying the current level of severity of an incident.

The compliance and performance manager was responsible for incident monitoring. All incidents were discussed in the daily handover meeting. The compliance and performance manager checked the quality of incident reports and reviewed the categorisation of each incident. Where there were issues over incident recording this was discussed in the handover meeting and actions were assigned to be completed.

Staff offered to spend time with patients following an incident to provide them with support. Staff documented the meeting with the patients in their care records.

Staff received a team debrief following incidents. Staff told us that if they were involved in a serious or challenging incident, they had access to an external free counselling service and would be supported by the human resources manager.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

All patients received an assessment of their individual needs on admission. Physical health was monitored on an ongoing basis; the physical health nurse employed by the hospital oversaw this. Patients' physical health problems were mostly care planned. However, we reviewed the care records of two patients with physical health diagnoses and neither had a care plan to manage their diagnosis.

Care plans were personalised and reviewed regularly. Patients had personal profile folders which contained 'about me' grab-sheets. There was person-centred information about the patient's preferences, routines,

communication needs and positive behaviour support plans. There were examples of easy read adapted positive behaviour support strategies in patient care records. Patients' paper and electronic records were stored securely.

Best practice in treatment and care

Patients were given the opportunity to be involved in making decisions about their medicines. Consent to treatment forms were in place and there was a written record of the patients' views.

Patients were supported to complete the Symptom Checklist-90-R assessment within 72 hours of admission. This provided guidance on whether the patient was ready for therapy. Psychology staff used a range of assessments to determine which therapies were suitable for each patient. A range of assessments were used by psychology staff to help make decisions with patients about the therapy offered to them. These included the Weschler Adult Intelligence Scale, Beck Depression and Anxiety Scales, Novaco Anger Scale and Provocation Inventory and the Beliefs about Voices questionnaire. Psychological therapies were tailored to the patients' level of understanding, strengths and needs. The psychology team ran a social skills group which at two levels of difficulty, and targeted using patients' self-report of their skills. The Weschler Adult Intelligence Scale (WAIS-IV) was used to know how to adapt therapies for patients.

The service had recently employed a part-time physical health nurse. The physical health nurse was responsible for coordinating physical health checks with the GP, providing advice and support to staff and delivering training on physical healthcare. Patients had received annual physical health checks and had their physical observations checked regularly.

At our last inspection in May 2017, patients did not have access to easy read documents. However, on this inspection, we found that the hospital had employed a speech and language therapist that had developed a number of easy read documents for patients with a learning disability. These included: 'this is me' and a handover sheet for patients to complete prior to the multidisciplinary meeting to support them to feedback on how they are feeling, a personalised therapeutic activity plan and all their care plans.

Patients had the opportunity to work in the hospital shop. We were greeted by a patient who was very proud to work in the shop and explained he checked the stock, counted the cash and trained up new staff under the supervision of the occupational therapy assistant.

Staff completed the Health of the Nation Outcome Scales developed by the Royal College of Psychiatrists for each patient to identify the effectiveness of treatments at the hospital.

The provider had a schedule for completing clinical audit.

Skilled staff to deliver care

At our inspection in May 2017, the hospital was unable to offer psychological therapies recommended by the National Institute for Health and Care Excellence. However, on this inspection, we found that the hospital had a full multidisciplinary team to provide input to patients. They included; consultant psychiatrist, clinical and forensic psychologists, occupational therapists, a social worker, a speech and language therapist, nurses, healthcare assistants and therapy assistants. The provider had a contact with a national pharmacy that visited weekly; a pharmacist was present on the day of our inspection. However, the speech and language therapist was concerned she was not trained in dysphagia.

There was a lack of registered nurses experienced and skilled in working with patients with a learning disability. Out of 40 nurses working at the hospital, there was one permanent, two bank and one locum registered learning disability nurses. The remaining 36 nurses working at the hospital were registered in mental health and not learning disabilities.

There were inconsistencies in the thoroughness of staff inductions. Permanent staff received a corporate induction. Staff told us that permanent employees received a corporate induction but locum agency workers on long term contracts did not. Agency staff, received a ward orientation which was a tick box checklist of essential areas they needed to be aware of to carry out their roles. However, when we checked the orientation checklist against the agency staff member's staff profile, we found that 12 out of 27 agency staff had not completed a ward orientation.

Not all staff received supervision regularly. The data we received from the service prior to inspection showed a high

percentage rate for clinical supervisions. For example, in February 2018 100% staff had received clinical supervision. However, when we asked for the supervision records we were told that some were held on the wards and not centrally. We reviewed the supervision records folder on Mattingley ward and found that seven out of 15 staff did not have any supervision records in the folder. Ninety per cent of non-medical staff had received an appraisal within the last 12 months.

There was limited training in learning disabilities. We asked how many staff had been trained in learning disabilities but the provider was unable to tell us without pulling out each individual staff record. We asked to see the training that was delivered but the provider was unable to show us.

Poor staff performance was managed well. At the time of our inspection there were staff going through a capability process and there were no current disciplinaries. We reviewed four separate staff records where the disciplinary policy had been actioned. Investigations were thorough and disciplinary sanctions were appropriate. Where necessary, the service had made referrals to the Nursing and Midwifery Council and the Disclosure and Barring Service.

Multi-disciplinary and inter-agency team work

The hospital held daily handover meetings attended by heads of department to communicate hospital updates, changes to risks, incidents and plans for the day. Staff held ward based multidisciplinary meetings on a monthly basis. The consultant psychiatrists held weekly drop-ins for patients specifically wishing to see them. The multidisciplinary meetings were attended by the full multidisciplinary team and the patient. Patients' care was thoroughly reviewed by the team at these meetings.

There was good communication and oversight of risk across the hospital at the daily handover meetings. The daily handover meetings were attended by representatives from each staff group. Topics of discussion included: patient risk, activities, feedback from ward community meetings, new admissions and referrals, safeguarding and security.

Care coordinators were invited to care programme approach meetings. Where care-coordinators were unable to attend, staff kept in touch on the telephone and in writing.

There were good relationships between the hospital and the police. There was a designated police liaison officer for the hospital. The police liaison officer attended the hospital on a monthly basis for liaison meetings and if there were any incidents that required police involvement. The police felt there had been improvements within the hospital in managing incidents and reducing police time spent inappropriately. There had been a high number of patients contacting the police through the 999 service. Staff had worked with the police to educate patients on using the 101 service and as a result the amount of calls through to 999 had significantly reduced.

Adherence to the MHA and the MHA Code of Practice

Staff maintained clear records of patients' leave. The leave plan described the type of leave the patient was authorised for and the staff support required. The record showed observations made whilst the patient was on leave. If leave was denied to a patient the nurse in charge would offer a one-to-one meeting to discuss this with the patient.

The service could not evidence how many staff were trained in the Mental Health Act because agency staff profiles were out of date. Although the provider had assurance about the substantive staff, there was no assurance about the 89.1% of agency staff.

Staff adhered to Mental Health Act treatment requirements. We reviewed five prescription charts on Bramshill ward and eight prescription charts on Winchfield ward. All prescription charts had accompanying consent to treatment forms. The hospital requested second opinion appointed doctors as required. Treatment forms matched the prescription charts and capacity assessments were in place for patients being administered psychotropic medication. However, capacity assessments were not in place for patients that were administered non-psychotropic medication where there had been doubt about patients' capacity. This meant that patients may have lacked capacity to consent to non-psychotropic medication and were being administered it without the legal process required under the Mental Capacity Act.

Patients had their rights explained to them under the Mental Health Act. Records showed that staff explained patients' rights verbally and in writing, patients' rights were also given in easy read format.

Requires improvement

Wards for people with learning disabilities or autism

Staff were able to request legal advice and support from the Mental Health Act administrator based at the hospital. There was a regional Mental Health Act Manager who supported and supervised the hospital administrator.

Mental Health Act detention papers were in good order. Documentation was accurate, up to date and stored securely.

The Mental Health Act was monitored through quarterly audits. The Mental Health Act administrator was responsible for completing the audits and checked compliance against the code of practice. There was evidence that when the audit had picked up errors, appropriate actions were completed. For example, a recent audit identified that three patients did not have their current consent to treatment certificates with their prescription charts, this was rectified after the audit.

Patients had access to Independent Mental Health Advocates where necessary. The Independent Mental Health Advocates visited the wards weekly and met with every patient that wished to see them. There were posters on the walls of the wards advertising the advocacy service. Posters had a picture of the advocate so that patients knew who they were.

Good practice in applying the MCA

The service could not evidence how many staff were trained in the Mental Capacity Act because the agency staff profiles were out of date. Permanent staff received Mental Capacity Act training as part of their corporate induction. Staff told us they received face-to-face Mental Capacity Act training annually.

In the last six months there were three Deprivation of Liberty Safeguards applications made to the local authority. There were delays in best interest assessments from the local authority; these were being followed up by the Mental Health Act administrator. The Deprivation of Liberty Safeguards file contained the standard authorisation from the local authority. It also contained copies of letters sent to the patient explaining that they their detention had been authorised and providing information to the patient. Information about advocacy and a booklet explaining what the Deprivation of Liberty Safeguards was.

Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us that Mental Capacity Assessments are usually completed in twos, often with the consultant psychiatrist and the psychology team. There was a Mental Capacity and Deprivation of Liberty Safeguards policy which staff had access to. Mental capacity assessments were decision specific. For example, there was an assessment of a patient's capacity to make decisions about their finances and a separate assessment of the patient's capacity to make decisions about where they live. Capacity assessments were clear and involved family members where necessary to support the patient to make the decision. Staff made best interest decisions with patients and their families; these were well documented in care records.

Staff used the least restrictive intervention when restraining or restricting a patient was necessary. Records showed that staff only supported patients to the floor as a last option and frequently tried to walk the patient to another area whilst holding them. Investigation records showed that when there had been incidents where staff had not used the least restrictive method, there was a full investigation and the member of staff was dealt with through disciplinary processes.

There was no local MCA lead at the hospital, the provider had a regional MCA lead who supported the site MHA administrator. However, staff in the service were unaware of this role. The Mental Health Act administrator was happy to support staff with the application of the Mental Capacity Act but felt they needed more training to do so.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

Patients on most wards were happy with the care they received. Patients said that staff were friendly and easy to talk to and they felt listened to. However, on Winchfield ward, we had a mixed response of positive and negative comments about staff.

Staff were interacting with patients in a warm and friendly manner. All patients were involved in some sort of activity and had regular contact with staff members and other patients. Patients seemed to know the staff members well.

Requires improvement

Wards for people with learning disabilities or autism

The involvement of people in the care they receive

Patients were orientated to the ward on admission and given information about the service from the admitting nurse and the patients' welcome pack.

Patients felt involved in the planning of their care. Patients could tell us what was in their care plan as they had been involved in writing it. All patients were offered a copy of their care plan. Patients were involved in the care programme approach process, a package of care which may be used to plan a patient's mental health care and is there to support recovery from mental illness. Patients relatives were invited to Care Programme Approach meetings with the patients' consent. There was evidence that patients' feedback was acted upon in daily ward community meetings.

Patients had access to the advocacy service. Patients knew who the advocate was because their picture was on the wall. The advocate visited every ward on a Friday and spoke with any patients that wanted to see them.

There was inconsistency in the involvement of families. We spoke with the three family members that were available; all three carers that we spoke with felt the care was good. One carer felt the communication was excellent, however, the other two carers felt they were not always communicated with.

Patients could feedback about the day-to-day issues on the ward at community meetings or in one-to-ones with their keyworker. Patients saw the community meeting as a forum to raise issues about the kitchen menu, environmental concerns and any changes they would like to the activity plan. Patients were also invited to the restrictive practice meeting where they could feedback about the level of control there was on the wards.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

The average bed occupancy over the last six months on Winchfield ward was 65% and 91% on Heckfield ward between 01 September 2017 and 28 February 2018.

There had been four delayed discharges between 01 January 2016 and 28 February 2018. All delayed discharges were due to a lack of suitable placement opportunities to meet the patients' needs.

Patients told us that staff showed them around the ward when they were first admitted and introduced them to staff and patients. Patients received a welcome pack on admission.

Patients were only moved to another ward for clinical reasons. Staff would not transfer a patient to another ward at an inappropriate time of day and always tried to transfer patients in the mornings.

All patients had a discharge date with an accompanying plan in their care records.

Patients' care plans referred to section 117 aftercare services for patients on the relevant sections of the Mental Health Act.

The facilities promote recovery, comfort, dignity and confidentiality

All wards had adequate rooms for therapies and activities. All wards with the exception of Bramshill ward had quiet areas for patients to spend time in.

Patients were allowed their own mobile phones if they had them. Mobile phones were only permitted on the wards if there was no camera function and they were a basic style phone with no internet access. Patients kept their phones on them in the day to make and receive calls and handed them in at night to be charged. There were also soundproofed phone booths on the wards but the door on the phone booth on Bramshill ward did not close properly, meaning that patients could not make private phone calls when using the pay phone.

Patients on all wards had access to outside space. However, the only ward that had outside seating was Heckfield ward; this had been raised previously at our Mental Health Act review visits. We raised this again during this inspection and the hospital manager assured us they would address this.

Patients did not enjoy the food. Out of the nine patients we interviewed about the food, seven patients were not satisfied with the quality or the quantity. However, there had been no formal complaints about food raised with the service.

Food safety checks were not completed consistently. Out of 14 patients interviewed, two patients said the food was always cold. The patients told us that the food is often cold because the trolley is left outside the ward for some time before it goes onto the ward to be served. We reviewed the food temperature records and found that temperature checks were completed in the main kitchen but food was not being temperature probed on the individual wards.

Patients had access to hot drinks and snacks. Patients on some wards had to ask staff for snacks due to risk issues with the patient group. Some wards had fruit on tables and others had water machines available to patients.

Patients' bedrooms on all wards were personalised. Some patients had televisions, computer consoles and radios in their rooms, these were risk assessed on an individual basis.

On Winchfield ward, there was a store room which was supposed to be used as a security room containing items that were not allowed on the ward. However, it had become a store room over time and patients' personal items were piled on top of each other from floor to ceiling, unlabelled, loose and not in bags. We asked the staff about how they kept control of what was in the store room and we were told that each patient had an inventory in their care records. On one wall within the store room, there was a shelf with an open hatch. People passing by the other side of the hatch could have easily put their hands through the hatch and removed patients' property. At the time of our visit there were patients' belongings within easy reach of the hatch that could have been taken by anyone leaving or entering the building.

Patients had access to a range of activities on and off the wards. Patients used their leave outside in the community, to go to the cinema, bowling and shopping. Some patients had recently joined a football league entering their own team, we witnessed them training in the grounds of the hospital during our visit. During our visit to Eversley ward, we observed staff interacting with a patient using Makaton. The patient was given the opportunity to sign with staff to communicate what activity he wanted to take part in. On the wards there were activities such as film nights, gardening, cooking, budgeting and book keeping. However, on Winchfield ward on the first day of our inspection, there were activities written up onto the white board but there were no pictures for patients that were unable to understand the words. On the second day of our visit when on Winchfield, ward there were no written or pictorial activities on the whiteboard when we visited at 11:30am.

Meeting the needs of all people who use the service

Adjustments had been made throughout the hospital for patients with disabilities. All wards had accessible information available. Patients had information available to them about mental and physical health issues, treatments and local services, advocacy and how to make a complaint. There was pictorial signage on doors on all wards. Interpreters could be accessed if required for patients whose first language was not English. Patients' communication needs were written in their care plan and communication passports. Patients and staff attended Makaton training twice per week following community meetings.

Patients had a range of meal options. There was a choice of vegetarian, gluten free and halal food.

A vicar visited the ward once per week.

Listening to and learning from concerns and complaints

Between 23 March 2017 and 22 February 2018, there were a total of 21 formal complaints. Of those 21 complaints, four complaints were upheld and ten were partially upheld. No complaints were referred to the ombudsman.

Patients knew how to complain. Leaflets were in easy read format on all wards. Complaints were discussed at the ward community meetings; we reviewed records of these meetings which showed actions had taken place as a result of patient feedback. For example, a patient had reported that their shower was cold; this was being addressed with the maintenance team.

Complaint policy procedures were followed and each complainant was informed of updates and outcomes of investigations. Each decision was clearly recorded.

Requires improvement

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism well-led?

Requires improvement

Vision and values

Staff shared the vision and values of the organisation. Staff told us their objective was to keep patients safe, treat them as individuals and prepare them for discharge. Staff told us there was an expectation that they were open with one another and communicated as a team. The organisations values were discussed at team meetings.

Staff knew who the senior people were within the organisation and told us they visited the wards regularly. Staff told us the service had improved significantly and they felt well supported by management.

Good governance

There was a mandatory training schedule in place and staff told us they had been trained in key areas. However, because of the high level of agency and locum staff working at the hospital and the lack of information about what those staff members were trained in, we were not assured that all staff had received mandatory training.

Not all staff were supervised. There was not an effective overview of staff supervisions. There were different systems in place for recording supervision. However, the quality of the supervision records we reviewed was good.

There was a good ratio of staff to patients on all wards. Patients told us there was always enough staff to meet their needs. There was a high number of agency locum staff, however, these staff were working medium to long term contracts to provide consistency to patients. Activities were rarely cancelled due to lack of staff and patients told us they had one-to-one time with staff when they needed it.

There were a number of ongoing audits across the hospital. Audit outcomes were fed back into the clinical governance meeting and health and safety meeting. We were not assured that outcomes were fed back to staffing teams to improve safety and standards of care.

Staff told us they reported openly and accurately. Incidents were discussed thoroughly within various meeting forums and the outcomes of these reached the staff teams.

Records showed an inconsistent governance system was in place. There was an overview of health and safety issues. Meeting minutes reviewed showed discussions had taken place about health and safety based on feedback from staff and patients. Actions had been identified and taken place. However, there was no overview of training across the hospital and the provider was unable to provide an overview of the frequency of prone restraints.

Ward managers were supported by the hospital administrators to carry out their roles.

Ward managers were aware of the risk register. There had been discussions about adding to the risk register but as the ward managers were new in post, they had not needed to do this. Ward managers felt they could raise concerns about risks within the hospital.

Leadership, morale and staff engagement

Staff felt supported and encouraged by management and senior people within the hospital. Ward managers were signed up to complete a leadership and management course to support them in their roles. Staff morale was good. Staff across all wards told us they were happy in their roles and felt the organisation was improving all the time.

Sickness rates were high across the hospital. There were no staff on long term sick leave at the time of our inspection. There was a sickness and absence policy but as the sickness related to short term sickness across staff teams, the sickness policy had not been started with individuals.

There were no cases of bullying or harassment at the time of our visit. Staff knew how to whistle blow if they needed to. Staff were aware of the whistleblowing policy and process and told us they would raise concerns with management or human resources if necessary.

Commitment to quality improvement and innovation

The hospital was registered with The Quality Network for Forensic Mental Health Services accreditation. The service had recently been reviewed April 2018 and was awaiting the report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the risk of patients harming themselves where there are blind spots is mitigated.
- The provider must ensure that the risk management of ligatures is thorough.
- The provider must ensure that the clinic room on Winchfield is well maintained and that emergency equipment and medication is available.
- The provider must ensure that staff are trained to the standard set out in their staff training policy.
- The provider must ensure that staff are following post rapid tranquilisation protocol.
- The provider must ensure that food is served to patients at a safe temperature.
- The provider must ensure that staff assess patients' capacity in line with the Mental Capacity Act.
- The provider must ensure that the governance of the number of staff trained are kept reviewed and monitored.
- The provider must ensure that staff receive regular supervision and support.
- The provider must ensure they are monitoring different types of restraint effectively.
- The provider must ensure that staff receive training which meets the needs of the client group.

Action the provider SHOULD take to improve

- The provider should ensure that all staff receive an orientation to the ward they are working on.
- The provider should continue to ensure that staff follow infection control procedures.
- The provider should continue to prioritise bathing protocols for patients that have epilepsy.
- The provider should ensure that patients have access to outside seating.
- The provider should ensure that the Mental Health Act administer is provided with training to oversee the Mental Capacity Act within the service.
- The provider should ensure there is medication available to reduce the effects of benzodiazepine medication.

The provider should ensure patients' telephone conversations on Bramshill ward are private and confidential.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. Patients were not protected from the risk of adverse side effects from medicines that were administered by not following post rapid tranquilisation protocol Patients were not protected from the risks associated with blind spots which were not mitigated. Ligature risk assessment management plans were not thorough. The clinic room on Winchfield was not well maintained and not all emergency equipment and medication was available. Infection control procedures on Bramshill ward were not being followed. These were breaches of regulation 12 (2) (a) (g) (h)

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

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing Agency staff were not trained to the standard set out in the staff training policy. Staff did not receive training that met patients' needs. This was a breach of regulation 18(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Good governance The provider did not have a sufficient overview of the training compliance across any of the wards The provider did not have a clear overview of the frequency of prone restraints This was a breach of regulation 17(1)(2)(d)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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