Brookdale Healthcare Limited

Milton Park Therapeutic Campus

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We rated Milton Park Therapeutic Campus as inadequate because:

- Gifford A and B and Cooper 1 and 2 were not clean, were poorly maintained and had unpleasant smells. These areas were not maintained in line with infection control standards
- The safeguarding lead had not received relevant training
- On Gifford B, two fire extinguishers were past their expiry date of February 2015
- Staff did not check resuscitation equipment regularly or make sure that this equipment was sufficiently available

Summary of findings

- Not all staff had received mandatory training, with gaps in safeguarding children and adults training for staff, infection control, life support and defibrillator training
- An effective induction was not in place for agency and bank staff
- There were not enough staff on duty to meet the needs of patients. This meant that escorted leave and unit activities were regularly cancelled. Due to a lack of attendance records, the provider were unable to demonstrate activities were delivered as planned.
- The hospital used high levels of agency and bank staff meaning patients did not always know staff working on the wards.
- On Cooper 1 and 2 had obstructed lines of sight, which meant that staff could not properly observe patients and ensure their safety
- Potential ligature points were found in some units that had not been appropriately mitigated
- There was a breach of ministry of justice conditions for one patient
- Some practices were restrictive such as restricting patients' access to fresh air. Staff did not use long-term segregation correctly
- The seclusion suites did not meet the requirements of the Mental Health Act code of practice
- The incidents of restraint were high on wards Cooper 1, Ashwood and Cooper 3. The hospital were not taking steps to reduce the number of incidents of restraint
- Staff induction training was not updated or refreshed. Only 23 staff had completed their induction training out of 112 staff
- The hospital had not provided age-appropriate care and treatment for a 17 year old patient. Appropriate environmental arrangements, educational provision, and specialist staffing were not in place
- There were no effective systems for identifying, capturing and managing issues and risks at unit and organisational levels.
- Some patients reported staff were not always aware of their individual needs
- There was a lack of discharge planning for patients moving to residential care services
- The hospital received 208 complaints from January 2015, 86 of which were upheld. While staff knew the complaints process and showed patients how to register a complaint, the complaints system did not capture the lessons learnt or identify themes and trends in the hospital
- Significant issues that threatened the delivery of safe and effective care were not identified or action taken.
- The information systems were a combination of paper and electronic records. This caused difficulties for staff while updating and reviewing patients care records
- There was some engagement with relatives of patients, carers, and the public. The hospital did not respond to what patients' relatives, carers, and the public said. As a result, their views were not reflected in the planning and delivery of the service
- There was a lack of openness and transparency, which resulted in the identification of risk, issues and concerns being discouraged
- Patients were able to personalise their bedrooms. However most bedrooms were not personalised. This was the responsibility of staff on wards, together with the individual patient. The lack of personalisation of bedrooms was a feature throughout the hospital.

However:

- Medical records and medicine management systems were robust and ensured that patients received their medication as prescribed
- There was good access to physical health care, including access to specialists when needed. Physical healthcare screening was completed as part of the admission assessment process

Summary of findings

- Care plans were updated regularly with the information required by staff. Patients understand, and had a copy, where possible, of the information that is shared about them.
- Staff had regular supervision
- The hospital complied with the legislative requirements of the Mental Health Act. Patients were supported to make decisions and, where appropriate, their mental capacity were assessed and recorded. Staff used outcome measures
- There was a choice of food to meet the specific dietary requirements of religious and ethnic groups
- There were examples of positive patient and staff interactions seen on all units. There were particularly caring and respectful interactions between patients and staff on Ashwood unit
- Patients and staff knew the senior hospital managers and they regularly visited the units
- Staff knew and agreed with the organisation's values
- Staff told us there was good team work on the units, access to specialist training, and opportunities for leadership development.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We rated safe as inadequate because:

- Gifford A and B and Cooper 1 and 2 were not clean, were poorly maintained and had unpleasant smells. These areas were not maintained in line with infection control standards.
- The safeguarding lead had not received relevant training.
- On Gifford B, two fire extinguishers were past their expiry date of February 2015.
- Staff did not check resuscitation equipment regularly or make sure that this equipment was sufficiently available.
- Not all staff had received mandatory training, with gaps in safeguarding children and adults training for staff, infection control, life support and defibrillator training.
- An effective induction was not in place for agency and bank staff.
- There were not enough staff on duty to meet the needs of patients. This meant that escorted leave and unit activities were regularly cancelled. Due to a lack of attendance records, the provider were unable to demonstrate activities were delivered as planned.
- The hospital used high levels of agency and bank staff meaning patients did not always know staff working on the wards.
- On Cooper 1 and 2 had obstructed lines of sight, which meant that staff could not properly observe patients and ensure their safety.
- Potential ligature points were found in some units that had not been appropriately mitigated.
- There was a breach of ministry of justice conditions for one patient.
- Some practices were restrictive such as restricting patients' access to fresh air. Staff did not use long-term segregation correctly.
- The seclusion suites did not meet the requirements of the Mental Health Act code of practice.
- The incidents of restraint were high on wards Cooper 1, Ashwood and Cooper 3. The hospital were not taking steps to reduce the number of incidents of restraint.

However:

- We found medical records and medicine management systems were robust and ensured that patients received their medication as prescribed.

Is the service effective?

Good

We rated effective as good because:

Summary of findings

- There was good access to physical health care, including access to specialists when needed. Physical healthcare screening was completed as part of the admission assessment process.
- Care plans were updated regularly with the information required by staff. Patients understood, and had a copy, where possible, of the information that was shared about them.
- Staff received regular monthly supervision.
- The hospital complied with the legislative requirements of the Mental Health Act. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. Staff used outcome measures.

Is the service caring?

Good

We rated caring as good because:

- There were examples of positive patient and staff interactions seen on all units. There were particularly caring and respectful interactions between patients and staff on Ashwood unit.
- On Gifford A unit, staff provided practical and emotional support to a patient to assist them in managing their own behaviour.
- Patients were involved and participated in care planning and risk assessment processes.

Is the service responsive?

Requires improvement

We rated responsive as requires improvement because:

- The hospital had not provided age-appropriate care and treatment for a 17 year old patient. Appropriate environmental arrangements, educational provision, and specialist staffing were not in place.
- Some patients reported staff were not always aware of their individual needs.
- There was a lack of discharge planning for patients moving to residential care services.
- The hospital received 208 complaints from January to August 2015, 86 of which were upheld. While staff knew the complaints process and showed patients how to register a complaint the complaints system did not capture the lessons learnt or identify themes and trends in the hospital.
- Patients were able to personalise their bedrooms. However most bedrooms were not personalised. This was the responsibility of staff on wards, together with the individual patient. The lack of personalisation of bedrooms was a feature throughout the hospital.
- There was access to activities, but patients and staff told us activities were often cancelled because of staffing shortages.

However:

Summary of findings

- There was a choice of food to meet the specific dietary requirements of religious and ethnic groups.

Is the service well-led?

Inadequate

We rated well-led as inadequate because:

- There were no effective systems for identifying, capturing and managing issues and risks at unit and organisational levels. Leaders did not understand and manage risks.
- Significant issues that threatened the delivery of safe and effective care were not identified or action taken.
- There was some engagement with patients' relatives, carers, and the public. The hospital did not respond to what relatives of patients, carers, and the public said. As a result, their views were not reflected in the planning and delivery of the service.
- The information systems were a combination of paper and electronic records. This caused difficulties for staff while updating and reviewing patients care records
- There was a lack of openness and transparency, which resulted in the identification of risk, issues and concerns being discouraged.

However:

- Patients and staff knew the senior hospital managers and they regularly visited the units.
- Staff knew and agreed with the organisation's values.
- Staff told us there was good team work on the units, access to specialist training, and opportunities for leadership development.

Milton Park Therapeutic Campus

Detailed findings

Background to this inspection

Our inspection team was led by:

Lyn Critchley, inspection manager, mental health.

The team that inspected Milton Park Therapeutic Campus consisted of:

- one CQC manager
- two CQC inspectors
- one CQC inspection assistant
- two Mental Health Act reviewers
- one psychiatrist
- two mental health nurses
- one learning disability nurse
- two experts by experience.

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

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited eight units: looked at the quality of the hospital environment and observed how staff were caring for patients
- met with 21 patients who were using the service
- interviewed three senior team leaders and one unit manager
- interviewed 15 managers of the service and those with lead roles within the team
- spoke with 12 staff including nurses, support workers and occupational therapists
- attended and observed one multidisciplinary meeting and one staff handover.
- looked 11 care and treatment records of patients
- carried out a specific check of the medication management records of four patients
- looked at policies, procedures and other documents relating to the running of the hospital
- collected feedback from seven patients using comment cards.

Information about the service

Milton Park Therapeutic Campus provides care, treatment and support for people on the autistic spectrum, and support with mental health concerns, anxieties or learning disabilities.

Detailed findings

The hospital had 11 units for people who require low-secure and locked rehabilitation. The units were made up of a group of small houses within a short walking distance of each other. Three units, Elstow 3, Elstow 4 and Elstow 5 were ready for use, but unoccupied. At the time of inspection, eight units were open and there were 44 patients receiving care and treatment.

- Ashwood unit provides seven beds for women. This unit is for people with autism, personality disorders, challenging behaviour and other mental health diagnoses. The unit is split over two floors and has an upstairs quiet annex.
- Elstow 1 provides three beds for women. This unit is for people with autism personality disorder challenging behaviour and other mental health diagnosis.
- Elstow 2 provides six beds for younger men.
- Cooper 1 unit provides six beds for men. This includes a psychiatric intensive care unit (PICU) service on the ground floor and two larger rooms on the first floor.
- Cooper 2 unit provides seven beds for men with a learning disability.
- Cooper 3 unit provides three beds and is described by the provider as an intensive behavioural support service (IBSS). This unit is designed for people with behaviours seen as challenging. This unit has a sensory room.
- Gifford A provides eight beds for men and is a locked rehabilitation ward
- Gifford B provides four beds for men and is a locked rehabilitation ward.

The provider, Brookdale Healthcare Limited, was purchased by Tracscare a few weeks before our inspection. There was a registered manager and an accountable officer.

Milton Park Therapeutic Campus registered with CQC in 2005. The CQC has carried out four inspections since 2010. Routine inspections were carried out in July 2011, September 2012, May 2013, and an inspection to check improvements in August 2013. Improvements were around staffing and record keeping. There was a Mental Health Act review on Cooper 2 ward on 25 April 2014. Improvements made included re-instatement of the patients' weekly meetings, regular monitoring of the cleaning schedule, and spot checks on the environment.

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.

Patients had received their rights (under section 132 of the Mental Health Act) and these were repeated at regular intervals. Mental Health Act paperwork had been completed correctly, was up to date and held appropriately. Record keeping and scrutiny relating to the Mental Health Act was satisfactory.

Posters were displayed informing patients of how to contact the independent mental health advocate (IMHA).

The staff we spoke with had a good working knowledge of the Mental Health Act and 68% of staff working within this service had received training.

We found the provider had not complied with providing an age appropriate service under the Mental Health Act code of practice. People under 18 years should receive a service that meets their needs. The environment, education, and specialist staffing arrangements were not in place.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff members working within this service had received training in the Mental Capacity Act 2005 (MCA). This was as part of the staff training programme. Milton Park employed a specialist mental health act manager to support patients and staff with guidance around the MCA and Mental Health Act.

There was one DoLS application made within the last six-month period for one patient.

Records we sampled showed that patients' mental capacity to consent to their care and treatment was assessed on their admission and reviewed regularly.

What people who use the service say

We spoke with 21 patients. Patients told us they felt safe at the hospital and were pleased with the care provided.

However, some patients told us that some staff spent too much time in the office, and they were not always treated individually, and sometimes ignored. Patients told us that activities were frequently cancelled and there was not enough to do.

We read seven completed comment cards from patients, relatives and carers. These stated that the hospital was clean and hygienic and that staff met their needs. One relative commented staff did not pass on messages to family members and that staff did not communicate effectively with each other.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that action is taken to identify ligature risks and to mitigate risk where there are poor lines of sight
- The provider must ensure that action is taken to ensure that premises are kept clean and properly maintained in line with infection control standards
- The provider must ensure that the seclusion suites meet the requirements of the Mental Health Act code of practice
- The provider must ensure that an effective induction is in place for agency and bank staff
- The provider ensure that staff receive the appropriate training and support to enable them to meet individual patient
- The provider must ensure that there is sufficient, up to date, emergency equipment and fire equipment available
- The provider must ensure they use blanket restrictions only when justified and that safeguards are in place for patients when long term segregation is used
- The provider must ensure that there are robust patient discharge arrangements in place and there is discharge planning for patients when planning to leave the service
- The provider must ensure that there are sufficient, experienced, staff on duty at all times to provide care and treatment to meet patients' needs
- The provider must ensure that patients under 18 years of age receive age appropriate services
- The provider must have an effective governance process, including assurance and auditing systems in place to monitor the care and treatment provided to patients, including incidents of restraint.
- The provider must seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders.

Action the provider SHOULD take to improve:

- Ensure patients can personalise their bedrooms, where this is their choice
- Ensure private space available for patients to see their visitors on all units
- Ensure the patients' information handbook and written information about children's visiting is updated
- Ensure improved coordination between staff on the units and star centre staff to facilitate regular and regular patient's activities.

Inadequate

Is the service safe?

Our findings

Safe and clean environment

- Although the hospital completed ligature risk assessments, they were not available for Cooper 2 and Elstow 1 units. Ligature points are places to which patients intent on self-harm could tie something to harm them. However, we found potential ligature points on Elstow 1. In one patient's bathroom the taps, grab rails, the toilet flush and the call bell were potential ligature points. The layout of Cooper 2 unit did not allow staff to observe every area with a clear line of sight. This meant staff may not be able to keep patients safe in line with observational guidelines. Staff did not assess, monitor or manage risks to people who use the services. Opportunities to prevent or minimise harm were missed.
- The units complied with guidance on same sex accommodation, as there were separate units for male and female patients.
- Staff had not checked resuscitation equipment regularly and had not ensured that it was sufficiently available across the units. There were two defibrillators for eight units. On Cooper 1unit, we found the defibrillator was charged and ready for use, but had not been maintained. The required defibrillator pads' date had expired and were dated April 2011. On Gifford A unit staff told us the defibrillator was broken, but we found a brand new defibrillator still in its wrapper. Staff were not aware of the new defibrillator. The Mental Health Act code of practice requires that emergency resuscitation devices should be readily available in an area where restraint may take place.
- We asked staff on Elstow 2 unit to test out the emergency alarm system as if a patient had had a cardiac arrest. Fifteen staff responded to the unit within two minutes with resuscitation equipment. However, only two of the responding staff had been trained to use a defibrillator. Some staff, when interviewed, were unclear which units the defibrillators were held on. Staff told us they had never pulled the emergency cord to test the systems. We asked the provider to review emergency procedures and response times. There were inadequate plans in place to assess and manage risks associated with anticipated future events or emergency situations.
- We saw nurse call systems throughout the units. We observed staff activate alarms to summon staff assistance and respond to patients who were agitated or distressed. We saw staff on Gifford A unit positively respond and care for a patient with prolonged challenging behaviour.
- We looked at the seclusion facilities on Cooper 1 and Elstow 1. On Cooper 1 the facilities allowed for clear observation, two-way communication, and had toilet facilities and a clock. However, the facilities were dirty and had unpleasant smells. In Elstow 1 unit, the mirror in the seclusion room had a screw missing and was a potential hazard. There was no clear line of sight to observe the ensuite bathroom, no CCTV and no intercom. It was difficult to hear through the door as sound was muffled.
- The cleaning records confirmed that the units had been cleaned. However, despite this, units Gifford A and B, Cooper 1 and 2 were dirty and had unpleasant smells. On these units, some of the carpets were stained and worn. Paintwork, doors and walls were dirty with marks. Staff told us they cleaned the units in between caring for patients. Standards of cleanliness and hygiene were not maintained. On these units there were showers, but no bath.This meant that patients would have to go to other units if they wanted a bath. Following the inspection patients from Gifford A and B units moved to the refurbished units at Elstow 3 and 4.
- Each unit had an infection control lead and regular infection control meetings. The infection control action plan for 2014/15 had no set timescales. For example, some units required an installation of a hand wash sink and carpets to be replaced, but no timescales had been set. Equipment looked dirty and there was no evidence of cleaning stickers to confirm items were cleaned and in date. We saw from training records that staff did not receive regular infection control training. Standards of infection control were not maintained, and safety not a sufficient priority.
- We examined the unit maintenance logs where staff reported repairs. Some repair requests made in 2014 had not been completed, including repairs highlighted as urgent. Some requests relating to fire systems had not been met. For example, on Gifford B two, fire extinguishers were out of date since February 2015. Staff on Elstow 2 unit had made 21 requests for repairs from

February to July 2015 that had not been completed. On Cooper 1, one patient complained that their bedroom door handle self-locked when closed and had not been working for some time. Staff told us the door part had been ordered but the request had not been followed up. Safety concerns were not identified or addressed quickly enough. Care premises, equipment and facilities were unsafe.

- The annual 2015 maintenance plan required environmental risk assessments and ligature risks assessments to be undertaken. Fire risk assessments, legionella water checks, and daily and monthly health and safety checks were made across all units. However, there were ligature risk assessments for some units but not for Cooper 2 and Elstow 1 units. There was limited measurement and monitoring of safety systems for cleaning and general maintenance.

Safe staffing

- There were 20 qualified nurses working the week of our inspection. There were ten nursing vacancies. Nurses were supported by three service managers, one clinical quality lead and one practice nurse (a registered general nurse). There were 188 support workers at senior support workers and support worker levels. There were 41 support workers vacancies. This meant 10% of scheduled staff were qualified nurses to 90% who were unqualified staff during the week of our inspection. There was a high number of unqualified staff working as opposed to qualified staff.
- Managers told us they were undertaking reviews of staffing on a daily and weekly basis. The number of nurses on shifts was not sufficient. Staff told us nursing staff worked long hours and staff rotas confirmed this. Patients and staff told us that planned activities and escorted leave were frequently cancelled due to staff shortages. There were some records. These demonstrated there were gaps and escorted leave and activities were not regularly facilitated.
- The provider confirmed they were moving to a community nursing model. At our inspection nurses were based on units or worked across two units. In the future, the nursing model would mean nurses would not be assigned to a single unit but work across all units. This may mean reduced nursing availability. Low nurse staffing levels should be considered a risk factor for poor quality care.
- Staff told us there was a high reliance on temporary staff. However, they said that most agency staff were contracted to work regularly, which helped to improve the continuity of care.
- The provider gave us information about staffing. The number of shifts filled by bank and agency staff to cover sickness, absence or vacancies in a three month period were 1,317 against 11,777 by permanent staff. The sickness rate between August 2014 to August 2015 was 4% and the staff turnover rate was 10%.
- The nurse in charge was responsible for booking agency and bank staff. The duty rota was complex and each unit worked to a set shift pattern. We looked at staff rotas to see the levels of bank and agency staff, and if they had been inducted. Staff were not always allocated to a unit where they were best placed, depending on their skills and experience. An effective induction was not in place for agency and bank staff.
- There was a small group of response staff identified from units to assist staff with physical interventions. These staff had received specialised training. One staff member was on call from each unit 5pm to 9am in case of emergencies.
- There was enough medical staff to cover day and night shifts. The hospital employed a responsible clinician for core working hours. There was a responsible clinician cover for emergency cover and weekends, as well as office hours.A doctor could attend the ward quickly in an emergency. Staff told us that medical staff could be available within 30 minutes. There was always a doctor on call and they came to the hospital weekly to see patients. The hospital employed responsible clinicians for core working hours.
- The provider showed us training records for 112 staff. The quality of staff training was satisfactory but staff were not always able to take up training opportunities. Only 23 staff members 20% had completed the staff induction. There was a lot of variation in the number of courses staff had completed. Some staff had only attended one training course and others had attended up to 39 training courses. All but one staff member had

completed at least one course. We found safeguarding and first aid training was part of the induction training but had not been updated and renewed. Forty one staff had completed the safeguarding vulnerable adult's course equating to 37% of staff. Only seventeen staff had received safeguarding children training equating to 15%. Regular safeguarding children and adults training updates were not available. There was insufficient attention to first aid, safeguarding children and adults training. However, ninety per cent of staff had completed the securicare in-house physical interventions training.

- The safeguarding lead did not hold the appropriate level three safeguarding training. They had obtained level two training two and half years before our inspection, but had not renewed their safeguarding training. However, the provider confirmed the staff member would be attending advanced level safeguarding training in September 2015.
- Thirty staff members had completed infection control training, which equated to 27% of staff. Staff were not up to date with life support, defibrillator, emergency first aid response, and first aid training. Staff were unclear what level of training they should hold and how often it should be updated. Eight staff members were defibrillator trained out of 112 staff. We found some shifts where no staff on site were defibrillator trained. Senior staff told us that all staff were given basic first aid training and a risk assessment of first aiders on site was undertaken, but accepted there were first aid training gaps. Some staff had received training around safety management procedures in a hospital.

Assessing and managing risk to patients and staff

- Staff undertook a risk assessment for patients upon admission and updated this regularly and after every incident. Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and their activities timetable. These were updated at monthly multidisciplinary team (MDT) meetings, and at three / six monthly care programme approach meetings.
- Staff told us that where particular risks were identified such as a risk to self or to others, measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff were increased. We looked at 11 care records. The risk assessments had taken into account the patient's previous history as well as their current mental state, and were detailed.
- However, one patient's risk assessment on Gifford B unit had not been updated since March 2015. Another patient's ministry of justice authorisation set specific conditions for leave. These risks were not fully recorded within the hospital's section 17 leave authorisation or risk assessment. The patient had attended an outing in the community with two staff during our inspection, where the required conditions had not been met. There was a breach of ministry of justice conditions for this patient. Staff had not managed risks properly.
- We found some practices that were restrictive. On Elstow 2 unit, one patient had attempted to abscond through the garden. Since there was a blanket restriction in the garden area, which was kept locked to Elstow 2 patients and only opened upon request. On Ashwood unit, one patient told us that personal items had been removed from their bedroom and they were not informed when these would be returned, and felt they had been punished.
- Payphones were provided around the units where patients could make a phone call. There were rules about bringing mobile phones, laptops or computers to the campus for personal use. This included any tablet which was 3G or 4G enabled. Internet enabled mobile phones were required to be handed in to staff, and patients would be provided with a substitute basic mobile phone. This allowed patients to remain in contact with their family, carer (where appropriate) and representatives.
- Staff searched patients' bedrooms for items that were not allowed on the units. This was to ensure the safety of the patient and others. Information about banned items was contained in the hospital handbook.
- Information for informal patients was available in a patients' information leaflet displayed around the hospital 'Your rights as a voluntary patient', and information was in the hospital handbook.
- Staff on the units were able to describe what actions could amount to abuse. They were able to apply this

knowledge to the patients who used the service and described what actions they were required to take in response to any concerns. Staff knew the named safeguarding lead.

- Care and treatment records showed us that medicines were well administered. We found controlled drugs records were appropriately signed. Four medicine charts were seen, signed and dated. The records showed patients were receiving their medicines when they needed them. There were weekly stock control checks by the community pharmacist with records kept.
- The pharmacy room was small and had overheated. Staff confirmed the pharmacy air conditioning system had been reported for maintenance and was resolved during our inspection. Adequate ventilation would ensure medicines were protected. Fridge temperature monitoring records were maintained.
- Rapid tranquilisation was used in five instances. Staff followed the National Institute for Health and Care Excellence (NICE) guidance and monitored incidences when rapid tranquilisation was used. However, the rapid tranquilisation monitoring records were not easy to read.

Track record on safety

- There had been one serious incident in April 2015. This was reported to CQC and recorded on the incident system.
- There were 78 incidents of seclusion in the previous six months January to June 2015. The highest numbers of seclusion incidents were on Cooper 1, Ashwood and Cooper 3 units. There were two incidents of segregation in the same period, on Cooper 1 and Cooper 3. On Cooper 3, we found staff did not follow long-term segregation guidelines and did not carry out reviews. Senior managers were unclear as to whether the patients were in long-term segregation and so reviews were not in line with the Code of Practice. Senior managers confirmed they would update care practice, the ward information, care plans and other documentation to reflect the changes in the new Code of Practice by October 2015.
- Ninety per cent of staff working within the hospital had received training in de-escalation techniques and the use of physical interventions (securicare training). This met positive and proactive care guidance issued by the Department of Health. However, incidents of restraint were high and the provider had not looked at the levels of restraint and considered other strategies to minimise them.
- There were 673 incidents of the use of restraint between November 2014 to May 2015. These occurred across seven wards with the highest levels seen on Ashwood at 294 incidents and Cooper 1 at 204 incidents. Overall, restraint was used on 37 patients of which nine were on Ashwood ward and eight on Cooper 1. The provider told us that their restraint techniques do not permit patients to be managed in the prone position (face down). If a patient collapsed to the floor in the prone position staff would immediately secure and turn them onto their back. However, records confirmed that there were 15 restraint incidents where individuals were restrained in the prone position, with the majority of those on Ashwood and Cooper 1.

Reporting incidents and learning from when things go wrong

- There were daily, morning multidisciplinary meetings that discussed events from the previous evening/ day and planned the next steps. There were also monthly multidisciplinary meetings, which included a discussion of potential risks relating to patients, and how these risks should be managed.
- We saw no evidence of data, analysis of themes or trends around restraint. Ward staff told us they completed restraint records but did not know where the incident reporting went to, or were provided with any feedback.
- Staff told us they were debriefed and offered support after a serious incident. Managers would offer time off work, if needed. One member of staff had received an injury and was offered support. Clinical governance meetings minutes confirmed another staff member was offered support and thanked for their actions in supporting a challenging patient. They had intervened to help protect colleagues and safely managed a patient during an incident.

Good

Is the service effective?

Our findings

Assessment of needs and planning of care

- We looked at 11 care and treatment records of patients. Ten records had detailed assessments carried out for each patient and care plans were developed from the initial assessment. We found good metabolic screening was carried out and physical health checks on admission including history taking, physical examination and blood tests. However, we did not find evidence of health checks upon admission for one patient under 18 years.On-going monitoring of physical health problems was taking place. All records included a care plan that showed staff how to meet patients' physical needs and a positive behaviour support plan. There were a range of individualised risk assessments and these were reviewed monthly at multi disciplinary team (MDT) meetings.
- However, the quality of care plans differed on units Elstow 1, Cooper 2 and 3, Gifford A and Gifford B. We found some care plans to be detailed and highly personalised to the patients' needs and showed the patients' involvement in the care planning process. Other care plans did not have this level of expected detail. For example, two hospital passports had been left blank, one person's date of birth incorrect, and other people's information wrongly entered into a patient's care plan. Another example was that a care plan for a younger adult's immunisations and allergies section was missing.
- Care and treatment plans were inconsistent and there was a mix of electronic and paper versions. This sometimes caused difficulties for staff maintaining patients care records. The provider told us they were considering an electronic care planning system to improve the care planning, safety and continuity of care.
- Patients would plan a weekly activity timetable with their keyworker and held a paper copy. Patients were encouraged to participate actively in formal therapy sessions and social and recreational activities. This was part of an individualised treatment programme, which were often based on a positive behaviour programme. Activities included anger management, laundry skills, kitchen skills and trips out. However, patients told us often activities were not what they wanted. For example, one patient on Ashwood unit had ticked in their care plan "not interested" in yoga however yoga appeared on their weekly activity timetable. Other patients told us that activities were often cancelled due to staff shortages.

Best practice in treatment and care

- Staff used the spectrum star assessment and planning tool and incorporated this into person centred planning with every patient. Staff assessed patients using the Health of the Nation Outcome Scales to measure the health and social functioning of people with severe mental illness. Staff used the Malnutrition Universal Screening Tool a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obesity. The Cardiff Health Checks (a health screening tool) for people with learning disability was used for most patients following admission. The medication for Attention-Deficit/Hyperactivity Disorder was used in line with National Institute for Health and Care Excellence (NICE) Guidelines.
- Clinical staff participated in clinical audits. The hospital data showed there had been ten audits in the last six months. Governance meetings showed patients file audit in May- June 2015 with themes, compliance and action required. We did not see evidence of any other audits or any ongoing improvements, or re-audits.
- Occupational therapists and speech and language therapists worked across the units. We saw they worked closely with patients promoting their wellbeing and developing recovery action plans.
- There was good access to physical health care, including access to specialists when needed. The practice nurse and clinical lead had recently received smoking cessation training and were preparing groups and individual sessions for autumn implementation.
- The star centre was located within the hospital site. There was access to computers, a snooker table, a gym, a sofa room, and art room. There was a range of leaflets available covering a variety of informative topics, such as advocacy and complaints. An art therapist was employed three days a week. A small garden allotment was available on the hospital site. We observed a relaxed atmosphere with friendly supportive staff. The star centre and the units (except Elstow 1& 2) had use of their own mini bus. We received mixed feedback from

the patients. Most patients told us activities were frequently cancelled due to a shortage of staff. There were some records of when patients attended sessions and when activities were cancelled. There was poor coordination between the star centre and staff on the units.

Skilled staff to deliver care

- Patients had access to a wide variety of clinical skills and experience from the multi disciplinary team (MDT) which included psychologists, occupational therapists, therapy assistants, speech and language therapists, social workers, doctors, nurses, senior support workers and support workers and a pharmacist.
- The hospital was using the care certificate standards as the benchmark for support workers. The care certificate aims to equip staff with the knowledge and skills which they need to provide safe, compassionate care.
- Staff told us that some specialist training was available. However not all staff had accessed all the mandatory training. A patient arrived at the service with dyspraxia and staff asked for training to meet the patient's needs. This staff training was provided. Two staff had received level two signing training to assist when communicating with some patients.
- Staff told us there was a new 12 week induction probation period for all new staff. Twenty per cent of staff had completed the induction training. This included one week of mandatory training and unit specific training. At the end of the 12 week probationary period staff were assessed for competency. However, key training was not repeated.
- Staff told us some units were more challenging for new staff. Staff told us they had suggested to senior managers that new support workers in post should start work on the less challenging units until they had developed confidence. This may help to retain staff. Senior managers had not responded to this suggestion.
- Staff told us that supervision took place monthly and appraisals once a year. Unit records confirmed that staff received regular monthly supervision, but we were unable to access individual staff appraisal records as they were held at the head office. One senior staff member told us they had not received their annual appraisal in 2015.
- Staff sickness rates were low at 4% between August 2014 to August 2015 and staff were not paid for sick leave. Staff had access to occupational health services. Staff told us there were opportunities for promotion and staff development.

Multi-disciplinary and inter-agency team work

- The hospital employed a clinical and therapeutic multidisciplinary team of staff. This included psychologists, occupational therapists, therapy assistants, speech and language therapists, social workers, doctors, nurses, senior support workers and support workers and a pharmacist. Staff told us at any time the hospital had at least one psychiatrist, one psychologist and one speech and language therapist on duty. The responsible clinician, locum doctors and a local doctor provided medical support. At all other times staff had access to an on-call psychiatrist and senior manager.
- We observed one morning, multidisciplinary meeting during the inspection. We saw staff shared information about patients and reviewed their progress. Different professionals worked together effectively to assess and plan patients' care and treatment.
- One senior staff member lacked knowledge and awareness of inter-agency working with multi agency public protection arrangements (MAPPA). One patient was subject to MAPPA. The provider told us the staff member would receive further training. There were established links in place with the police and other agencies.
- We observed a staff handover on Ashwood unit. Each patient on the unit was reviewed separately. We saw a comprehensive exchange of information including mental health presentation, physical issues and fluid intake. We saw effective teamwork.
- The clinical and therapeutic staff were a regular presence on the units and during our inspection. We observed good interactions between the staff, patients and support workers. The only exception was there was poor coordination between the star centre staff and ward staff.

Adherence to the MHA and the MHA Code of Practice

Good

Is the service effective?

- Staff were trained in, and had an understanding of, the MHA and the guiding principles of the Code of Practice. Some staff confirmed they could seek advice and guidance from the mental health act manager based at the hospital. The manager confirmed the MHA policies and procedures were being updated in line with the MHA code of practice and would be ready in October 2015.
- Consent to treatment and capacity requirements were recorded and copies of consent to treatment forms were attached to medication charts. Patients had their rights under the MHA explained to them on admission and routinely thereafter. Detention paperwork was filled in correctly, up to date and stored appropriately. We found patients had access to the independent mental health advocate (IMHA) services and staff were clear on how to access and support engagement with the IMHA services. Patients had positive behaviour support plans which they were involved in drawing up.
- We found the provider had not complied with providing an age appropriate service under the MHA code of practice. People under 18 years should receive a service that meets their needs. The environment, education, and specialist staffing arrangements were not in place.

Good practice in applying the Mental Capacity Act

- Sixty eight per cent of staff at Milton Park were trained in the Mental Capacity Act, MHA and Deprivation of Liberty Safeguards (DoLS). One training session covered all three subjects. The 32% that were not trained were new staff who were booked onto training as part of their induction and awaiting their training date to take place.
- One patient receiving care and treatment during our inspection was subject to a DoLS.

Good

Is the service caring?

Our findings

Kindness, dignity, respect and support

- We spoke with 21 patients receiving care and treatment on the units. We observed how staff interacted with patients throughout our inspection.
- In general, staff appeared kind, caring and compassionate. We observed many examples of staff treating patients with care and compassion. We saw staff engaging with patients in a kind and respectful manner on most units, particularly Ashwood unit. We observed staff treating patients with respect and communicating effectively with them. Patients we spoke with were mainly positive about the staff in relation to the respect and kindness they showed to them.
- However, we saw one example where a staff member was openly annoyed when a patient talked to the Care Quality Commission (CQC) inspection team.
- In the 2014 patient survey, the hospital scored 'unsatisfactory' for respect and dignity. 88% of patients submitted a completed or partially completed return, 24% of patients disagreed that staff always knocked on their bedroom door, 16 % disagreed that staff supported their culture and faith needs, 21% disagreed that staff were calm and polite when they spoke to them, and 21% disagreed that staff listened to them and took notice of their views. The managers had compiled an action plan with a timescale for completion by 31 August 2015. We found action plans were still being completed with patients by the practice nurse, hospital manager, named nurse/keyworker and other staff

The involvement of people in the care they receive

- Patients told us, and care records showed, that they were involved in their care planning and reviews.
- Most patients told us they had been actively involved in planning their care. We saw that patients' views were recorded in their care plans. Patients were invited to the monthly multi disciplinary reviews along with their family where appropriate.
- Patients told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were by appointment and arranged in advance. On some units, there was a limited range of rooms for patients to meet their visitors.
- Patients had access to an advocate. Detained patients were entitled to see an independent mental health advocate (IMHA). We saw posters around the hospital telling patients how to contact either general or independent advocates, or unit staff could contact them. We saw easy read information about the Mental Health Act, medication and other information in the patient's handbook.
- Patients told us that children were not allowed to visit the hospital. The hospital booklet confirmed that children up to and including the age of 17 were not allowed to visit unless the multidisciplinary team had agreed this and a risk assessment had been completed. Patient's information handbook and other written information contained different information about children visiting.
- Patients told us they could attend community meetings on the units. We saw notes of community meetings from most wards. Community meetings would allow patients to give feedback to the service they received. There had been a patient survey in 2014. The survey was distributed to 34 patients, 29 patients responded by submitting a completed or partially completed return. The survey covered 10 areas that included decision making, and involvement and choice. An action plan showed improvements were in progress with over 30 actions. Some improvements had been made for patients including arranging a mobile dentist and regular check-ups for patients, posters on bullying displayed on units, and reinforcement of the complaints policy at the patient forum.

Requires improvement

Is the service responsive?

Our findings

Access and discharge

- The hospital was designed for up to 73 people but had adapted to a smaller number of beds. At the time of inspection there were 44 patients receiving care and treatment. There were 21 placements from outside the Luton and Bedfordshire area between February 2015 to August 2015.
- Patients and staff confirmed there was access to a bed upon return from leave.
- There were 19 patients discharged during the year to August 2015. There were five delayed discharges reported between November 2014 to May 2015. Three delays were on units Gifford A, Cooper 1 and Copper 2. Some of the reasons given were lack of inappropriate placements and the need for a specialist service to be built. The Milton Park strategic review 2014 confirmed the provider was seeking to reduce readmissions.
- There were residential care services managed by the same provider on the same site. These facilities shared ancillary staff and the star centre resources. Staff told us that 90% of patients discharged from the hospital would move to the residential care service on the hospital site. We could not see evidence whether staff fully considered what was the best option for the patient when planning for discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- Ashwood unit for female patients had use of two floors. Patients who were making a recovery stayed downstairs on the unit and patients that required increased levels of observation stayed upstairs. This arrangement supported patients' treatment, care and recovery as the downstairs area allowed for different therapeutic activities and support.
- There was an allocated smoking shelter at the rear of each unit. Some units had access to a garden area. A large grassed communal space was available and we saw patients and staff use this area.
- There was access to activities, including at weekends. The star centre was open on Saturday and could be opened on Sunday if required. They provided structured leisure, learning and therapeutic activities. We observed patients attend breakfast club, a social activity available in the mornings. Each patient had an activity timetable but no records were completed to confirm activities were undertaken. Patients and staff told us activities were often cancelled due to shortages of staff.
- Support staff would plan activities with patients each week. We saw a laundry activity was on one patient's activity timetable. Each unit had laundry facilities and patients were supported to develop independent living skills.
- Staff told us that some patients' artwork was displayed in a local community art exhibition and demonstrated patients' abilities and aspirations. Patients would undertake group work activities, litter picking in the village or volunteer at a local chilli farm. One patient was due to start a college course. A new garden allotment was available on site and had inspired some patients to garden. Politicians had visited to meet with patients and staff prior to the election in May 2015. Information was presented in a way that people would understand and that would encourage patients to use their democratic right to vote.
- Locked cupboards were available in patients' bedrooms to secure their possessions. We saw most bedrooms were not personalised. The décor was the same neutral colour and there was a "drab" look on all the units. Patients told us they were not allowed to choose a colour to paint their room or bring their own bedding.

Meeting the needs of all people who use the service

- A multifaith room was available in the star centre. We spoke with 21 patients and they told us the meals were generally good. One person said there was not enough to eat. Units had small kitchen areas and we saw snacks and drinks were available. Patients told us Saturday night was "takeaway night" and they could choose what type of meal they wanted. The kitchen provided a comprehensive range of food including choices to meet religious and cultural needs. Support staff told us one patient had a specific religious dietary need but this was not recorded in their care plan.

Requires improvement

Is the service responsive?

- Information in easy read and audio materials were available and covered medication, the Mental Health Act, local services, complaints, procedures and advice on how to get help. Some staff had trained in sign languages.
- We found one patient had not received an age appropriate service. They were an informal patient under 18 years, with restrictions on their movement, ground leave and community escort. The patient told us repeatedly that they wanted to leave the service but were worried they would be sectioned. There was no evidence of education and age appropriate activities being provided. There was some involvement by a locum CAMHS (Child and Adolescent Mental Health Services) consultant however there was no evidence of suitable input from other clinicians with specialist CAMHS training or experience. Following the inspection, the provider reviewed the patient's care and support package.

Listening to and learning from concerns and complaints

- Information about the complaints process was available on notice boards around the units and in the star centre. Patients we spoke with knew how to make a complaint. Staff knew the process and showed patients how to make a complaint. A new designated staff member was responsible for overseeing and handling all complaints. Complaints were investigated. However, the complaints system did not capture the lessons learnt or identify themes and trends in the hospital. Staff told us they did not receive feedback on complaints, or action taken as a result to improve the quality of care. Patients concerns and complaints did not lead to improvements in the quality of care.
- Prior to the inspection the provider stated there were 100 complaints reported between May 2014 to April 2015. Of these, 28 were upheld, three partially upheld, 68 not upheld and one was on-going. However, the hospital had received 208 complaints from January 2015 to the time of our visit, 86 of which were upheld. The highest numbers of complaints were for Gifford A unit (28) and Ashwood (28) and these two units also had the highest number of upheld complaints (12 and 7 respectively). Of the 12 Gifford A complaints upheld, 10 related to verbal and physical interactions with other patients, of which three were reported to safeguarding authorities. The two other Gifford A complaints were upheld and related to noise from a generator affecting sleep, and ingredients for cooking not available.

Inadequate

Is the service well-led?

Our findings

Vision and values

- Staff told us about the vision and values of Milton Park Therapeutic Campus. Staff told us that senior staff were approachable, open and receptive. This had improved over the last two years with some existing staff promoted and new staff recruited. Staff knew senior managers, and told us they regularly visited the units, supported staff with patients and were available.

Good governance

- A range of meetings took place including monthly clinical governance meetings. Other regular meetings held were morning meetings, MDT meetings, health and safety forum, infection control meetings and unit team meetings. While there was a governance structure in place managers were not stepping back and thinking about their problems in a systemic way. The content of these meetings focused on individual concerns rather than overall clinical governance. Quality and safety issues identified on some of the wards were systemic across the service but had not been adequately considered through the governance structure.
- There were no effective systems for identifying, capturing and managing issues and risks at unit and organisational levels. For example, the cleanliness and maintenance of some units was poor. The hospital had not identified and mitigated ligature risks. Staff did not check resuscitation and fire equipment regularly or make sure that this equipment was sufficiently available. The environment and seclusion facilities were poorly maintained. Mandatory training was not up to date. Evidence showed us that quality and safety checks were not robust. There was limited evidence of reflective practice at management level.
- Clinical staff participated in some basic clinical audits but it was unclear how effective these were. There was little evidence of continuous performance monitoring or improvement as a result of past audits.
- There were a high number of complaints received from patients, including repeat complaints. The complaints system did not capture the lessons learnt or identify themes and trends. There was no evidence of changes to practice as a result of complaints.
- The provider shared feedback from investigations, both internal and external to the service, across the senior management team, but did not share it with support staff working on the units. Ward staff told us there were no arrangements in place to discuss this feedback. There was a lack of openness and transparency, which resulted in the identification of risk, issues and concerns being discouraged.
- There were 673 incidents of the use of restraint between November 2014 to May 2015
- There was an over-reliance on bank and agency staff and difficulties in recruiting nurses. There were not enough staff on duty to meet the needs of patients. This meant that escorted leave and unit activities were frequently cancelled. While the number of new staff was increasing staff turnover was still high. While a recruitment plan was in place, managers had not acted on some suggestions from staff about how to improve retention.
- When we reviewed the provider's policies and procedures, we found that many were not dated or had passed the next review date. These meant that systems were not in place to ensure information was accurate and up to date.
- The provider used a mix of paper and electronic systems. This sometimes caused difficulties for staff maintaining patients' care records. The practice nurse could access system one for clinical recording but was the only person who could use it. However, the provider was considering an electronic care planning system to improve the care planning, safety and continuity of care.

Leadership, morale and staff engagement

- We spoke with staff from across the different staff groups. Senior staff told us about integrated teamwork, achievements, and of good leadership that was visible and helpful. Staff told us there was good teamwork on the units, access to specialist training, and opportunities for leadership development. Staff felt there was an open door policy and managers were usually approachable but did not always feel included in service improvement.
- Staff considered that morale was good and the service was heading in the right direction.

Inadequate

Is the service well-led?

- We found that most of the ward teams were cohesive and enthusiastic. Staff spoke positively about the management team on Ashwood unit. We saw a positive working culture within this team.
- Support staff told us they could attend morning meetings. The morning meeting hears the handover of the previous 24 hours and reviews all incidents and risk episodes. Most staff we spoke with said they felt well supported by their immediate manager, they felt they could raise concerns and their work was valued by them.
- A survey was sent to 166 staff across the hospital in 2014. Forty-three (26%) were returned. The results showed that 69% of staff would recommend their employer, 73 % hoped that they would be working for their employer in 12 months' time, 79% felt adequately trained and 72% felt satisfied with their job.

Engagement with the public and with people who use services

- The patient carer's forum had no recorded minutes or clear working arrangements. This meant patients representatives and those close to them were not all actively engaged and involved in decision-making.
- We received feedback from some stakeholders that the provider was not open to learning. They also said that patients' family and carers were not always involved as partners in the patients' care. Stakeholders told us that the hospital did not respond to what patient's relatives, carers, and the public say. We found some evidence of engagement with patient's relatives and carers in care planning and attending multidiscplinary meetings (where appropriate).
- A hospital patient's forum met regularly and discussed a range of issues, therapy groups, food, and trips out. On most units patients told us they could attend community meetings. Community meetings allowed patients to give feedback to the service they received.
- There had been a patient survey in 2014. The survey was distributed to 34 patients, 29 patients responded by submitting a completed or partially completed return. The survey covered 10 areas that included decision-making, and involvement and choice. An action plan showed some improvements were in progress. Some improvements had been made for patients including arranging a mobile dentist and regular check-ups for patients, posters on bullying displayed on units, and reinforcement of the complaints policy at the patient forum.

Commitment to quality improvement and innovation

- Incident reports and other records suggested that that some patients had displayed racist behaviour towards staff. The service developed a scheme to help patients work against racism. If a patient displayed racist behaviour, they were provided with a card and given a warning that would result in a one to one discussion with a member of the therapy team about racism. If the behaviour continued, the patient was asked to promote and distribute racism awareness stickers and posters around the units. If the behaviour still continued, the patient received a visit from a community police officer. This scheme raised patients' awareness, promoted staff wellbeing and ensured both patients and staff were respectful.
- The service had affiliations to a range of workgroups such as East of England Clinical Audit & NICE (EECAN). There were affiliations with the Universities of Hertfordshire, Bedfordshire, Luton and Northampton for student nurse placements, and Network Autism. Managers were discussing with the new board working towards AIMS accreditation for the psychiatric intensive care units, and looking at the Quality Networks for Learning Disability and Working Age Adults.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 Staffing.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** The hospital used high levels of agency and bank staff and patients did not always know staff working on the wards. Escorted leave and unit activities were regularly cancelled. There was not enough staff on duty to meet the needs of patients. Mandatory training was not up to date and at the level, it needed to be. There were shortfalls around safeguarding children and adults training, infection control, life support and defibrillator training. Induction training was not updated or refreshed. An effective induction was not in place for agency and bank staff. **This was a breach of Regulation 18(1)(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 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 Premises and equipment.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

This section is primarily information for the provider

Action we have told the provider to take

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 Safe care and treatment.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** Potential ligature points were found in some units that had not been appropriately mitigated On units Cooper 1 and 2 had obstructed lines of sight, which meant that staff could not properly observe patients and ensure their safety. Staff did not check resuscitation equipment regularly or make sure that this equipment was sufficiently available. One patient's authorisation of leave stated that they should not go anywhere where there were children. The Section 17 leave form did not make explicit the conditions of their leave and needs review. Units Gifford A and B, Cooper 1 and 2 were poorly maintained and had unpleasant smells. Staff did not keep these units clean and properly maintained in line with infection control standards. The seclusion facilities on Cooper 1 had unpleasant smells and poorly maintained. The seclusion facilities on Elstow 1 unit were poorly maintained. The mirror in the seclusion room had a screw missing and was a potential hazard. There was no clear line of sight to observe the ensuite bathroom, no CCTV and no intercom. It was difficult to hear through the door as sound was muffled. The seclusion suite did not meet the requirements of the Mental Health Act Code of Practice. **This was a breach of Regulation 15(a) (e).**

This section is primarily information for the provider

Action we have told the provider to take

This was a breach of Regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 Person- centred care.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** We identified a lack of discharge planning for patients moving to residential care services. We could not see evidence whether staff considered what was best for the patient when planning for discharge. **This was a breach of Regulation 9.1 (a) (b) (c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13. Safeguarding service users from abuse and improper treatment.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** We found some practices maybe restrictive. On Gifford B unit, care records confirmed if one patient refused their medication the previous night they cannot take leave the following day. On Elstow 2 unit, one patient had attempted to abscond through the garden. There was a blanket restriction in the garden area, which was kept locked and only opened upon request. On Ashwood unit,

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 16 Receiving and acting on complaints.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** The complaints system did not capture the lessons learnt or identify themes and trends in the hospital. Staff told us they did not receive feedback on complaints, or action taken as a result to improve the quality of care. **This was a breach of Regulation 16(2).**

Regulated activity	Regulation

one patient told us personal items had been removed from their bedroom and they were not informed when these would be returned, and felt they had been punished.

Long-term segregation was not used properly. On Cooper 3, we found long-term segregation guidelines were not followed and reviews were not being carried out. Senior managers were unclear as to whether the patients were in long-term segregation and so reviews were not in line with the Code of Practice.

The hospital had not provided age-appropriate care and treatment for a 17-year-old patient. Appropriate environmental arrangements, educational provision, and specialist staffing were not in place.

This was a breach of Regulation 13(4) (b) (d).

This section is primarily information for the provider

Action we have told the provider to take

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 Good governance.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The governance process, including assurance and auditing systems to monitor the care and treatment provided to patients were not robust.

We did not see audits of incidents of restraint, to reduce these.

The provider was not open to learning. There was minimal learning and reflective practice. There was some engagement with patient's relatives, carers, and the public.

This was a breach of Regulation 17(2) (a) (e).