Sturdee Community Hospital

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?	Good
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 Sturdee Community Hospital as requires improvement because:

- Managers had not ensured that the ligature audit was complete. There was no ligature audit for Aylestone unit or Foxton ward. Ligature points had been identified on Rutland ward including the blinds in the gym and sliding door in the corridor, but no action had been taken to reduce these specific risks. Managers had not identified blind spots throughout the service.
- Staff were not following the "to take out" (TTO) medicines policy. Staff recorded the medicines fridge as above eight degrees on 28 occasions in a two-month period.
- Doctors had not ensured that medication charts were written in accordance with guidance. We found one medication chart did not refer to the fact that Olanzapine and Lorazepam, prescribed for the same person, should not be administered within one hour of each other.
- Staff administered insulin to a patient from the medication trolley that was out of date.
- The hospital did not have an effective system of oversight for the delivery of its Mental Health Act administration functions. The hospital did not have a current or robust policy in place to cover the range of Mental Health Act administrator's obligations. Managers had not provided the new mental health administrator with sufficient training, guidance and mentoring.
- Managers did not ensure completion of quarterly external audits of all Mental Health Act paperwork.
- Incident recording was variable. While staff reported incidents and notified to CQC, seven out of twenty records checked did not include what actions managers had taken, or what lessons they had learned.
- The inspection team considered quarterly visits by an external pharmacist was not adequate. Visits that were more frequent may have picked up the issues found during the inspection.
- Staff had not updated patients individual occupational therapy activity plans to reflect their current needs. Individual activity plans did not detail how the patient would achieve their identified goals.

However:-

- Wards were visibly clean, well maintained and had good quality furnishings. The infection control policy was in date. Cleaning records were available. All staff carried personal alarms and ligature cutters.
- Staffing levels at the hospital were good. The hospital had their full establishment of nurses and a multi-disciplinary team to meet the needs of their patients, and recruitment drives had been successful.
- Ninety-four percent of staff had attended mandatory training.
- Staff carried out full physical healthcare examinations as required. Staff completed separate and comprehensive physical healthcare records for each patient. Staff addressed specific issues such as pressure sores, and signs and symptoms of potential sepsis.
- Communication systems in the hospital were effective. Staff, including support staff, catering and maintenance staff attended a range of in house meetings including daily briefings, community meetings, and integrated governance meetings. This ensured that all staff working at the hospital were familiar with the patients and their current needs. All staff felt informed about the wider issues affecting the hospital.
- Patients and staff planned, facilitated and attended the weekly interactive academic teaching sessions on a Thursday morning.
- There was a clear admission and discharge policy and procedure, overseen by the consultant psychiatrist in discussion with the multi-disciplinary team.
- Staff understood the provider's vision and values based on growth, recovery, ownership, warmth, and time and healing. A philosophy of positive risk taking and least restrictive practice underpinned the vision and values.

Summary of findings

- Managers made significant changes to policy and practice following feedback from previous inspections, complaints and incidents.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	

Summary of findings

Contents

Requires improvement

Sturdee Community Hospital

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Sturdee Community Hospital

Sturdee Community Hospital is part of the Inmind Healthcare Group. Located in Leicester, the hospital provides both locked and open rehabilitation for female patients with complex mental health disorder, some of whom were detained under the Mental Health Act 1983.

The hospital had a registered manager and a nominated accountable officer for controlled drugs at the time of inspection.

Since September 2016, the hospital had been operating as an all-female hospital. They had a 16-bedded ward known as Rutland ward; nine supported self- contained flats known as Aylestone Unit; and the former Foxton ward was used as a rehabilitation therapy unit. We inspected all wards and the flats on this basis.

At the time of the inspection, there were a total of 20 female patients, five patients in the semi-supported flats and fifteen patients on Rutland ward. Seventeen of these patients were detained under the Mental Health Act.

Sturdee Community Hospital is registered to provide the following regulated activities:

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

Sturdee Community Hospital first registered with the CQC in April 2011. There have been five Mental Health Act reviews of the hospital in 2013, 2014 and 2015, 2016 and 2017, four CQC comprehensive inspections, and one unannounced focussed CQC inspection in May 2017; the last comprehensive inspection of the hospital was in November 2016.

Following the unannounced focussed inspection in May 2017, we served requirement notices in relation to breaches of regulations of the Health and Social Care Act (2008) Regulated Activities Regulations 2014. The breaches were in relation to:

Regulation 12 Safe Care and Treatment:-

The provider did ensure that incident forms were fully completed and reviewed by staff.

The provider did not ensure that medication was prescribed safely and in line with guidance and law which increased the potential for overdose.

The provider did not clearly highlight in case notes patients physical healthcare needs.

Regulation 17 Good Governance:-

The provider did not ensure that records relating to the care and treatment of each patient were complete and up to date including Mental Health Act paperwork.

The provider did not ensure they had an effective system in place to assess, monitor and improve the services provided in relation to patient's case records.

We reviewed the breaches in detail at this inspection and found that the provider had taken actions to address most of the breaches and improve the care and treatment provided to patients. However, we found further issues relating to the administration of medication and governance around Mental Health Act oversight.

Our inspection team

Team leader: Debra Greaves CQC Inspector.

The team that inspected the service comprised one CQC inspection manager, one CQC inspector, and a variety of specialists: including a pharmacist, Mental Health Act reviewer and an expert by experience, who is someone with lived experience of the service being inspected.

Summary of this inspection

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

Before the inspection visit, we reviewed information that we held about the location and sought feedback from a variety of stakeholders.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the environments and observed how staff were caring for patients
- spoke with eleven patients who were using the service
- spoke with one carer of a patient who was using the service
- spoke with the registered manager, director of nursing and corporate governance, and clinical nurse manager
- interviewed 14 other staff members; including doctor, nurses, healthcare support workers, occupational therapy, forensic psychologist, administrators, housekeeper and chefs
- spoke with the safeguarding lead, Mental Health Act administrator, visiting pharmacist and health and safety consultant
- attended and observed four multi-disciplinary team meetings / briefings
- collected feedback from three patients using comment cards
- looked at 10 care and treatment records of patients
- carried out a specific check of the Mental Health Act functions including review of 16 Mental Health Act files
- carried out a specific check of the medication management including review of 16 prescription charts
- reviewed compliance with the providers current action plans
- 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 11 patients and one carer, and looked at the comments from three feedback cards.
- Patients said they felt safe in the hospital, and they told us they were pleased with the changes being made by the new manager. They were pleased that there was more focus on their physical health as well as mental wellbeing.
- Patients told us the variety and quality of food was good, they were able to personalise their bedroom space and staff understood their needs.
- Patients said they understood their rights under the Mental Health Act, and staff informed them of their rights in a way they could understand. Staff rarely cancelled section 17 leave, and if it was cancelled, patients were informed why and offered an alternative activity.
- One carer told us they were very happy with the care their family member was receiving at the hospital and felt that communication between them and the hospital had much improved in recent months.
- However, six patients stated that the range of planned activities was limited and not always challenging enough for them. Four patients did not understand how the planned activities on the ward helped them in their recovery goals.

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:

- Managers had not ensured that the ligature audit was complete. There was no ligature audit for Aylestone unit or Foxton ward. Managers had identified blinds in the gym and sliding door in the corridor on Rutland ward as ligature points, but they had not taken any action to reduce these specific risks. Managers had not identified blind spots throughout the service. However, there were convex mirrors in the corridors on Rutland ward.
- Doctors had not ensured they had written medication charts in accordance with guidance. One medication chart did not refer to the fact that staff should not administer Olanzapine and Lorazepam, for the same person, within one hour of each other. This could lead to serious heart dysfunction.
- It was unclear from the prescription charts when primary medicine reconciliation had occurred, and it was noted that the pharmacist was not involved in this process.
- Staff were not following the “to take out” (TTO) medicines policy. We saw medicines being dispensed to patients in unlabeled bags and containers.
- Staff had recorded the medicines fridge in the clinic as above eight degrees on 28 occasions during a two month period. On 26 of these occasions staff had not indicated what action they had taken to rectify the situation.
- Staff had removed insulin from the fridge and this was stored and administered from the medication trolley. Staff had not revised the expiry date as recommended and could not ensure that the efficacy of the insulin had been affected.
- Staff recording of incidents was variable. Not all incident reports indicated what support staff had given, or what changes staff had made to either the nursing observations or red, green, amber (RAG) environmental risk assessment rating following the incident.

However:

- Wards were visibly clean, well maintained and had good quality furnishings. The infection control policy was in date and staff demonstrated knowledge of infection control principles. Cleaning records were available and complete.

Summary of this inspection

- All staff carried personal alarms, which they used to summon help in an emergency. Staff had easy access to ligature cutters, and had received training on how to use them safely. There was a patient call bell in all clinical areas.
- Staffing levels at the hospital were good. The hospital had their full establishment of nurses and a multi-disciplinary team to meet the needs of their patients, and recruitment drives had been successful. Staff were encouraged to remain visible and on the ward and there was a qualified nurse in the communal areas at all times. There were enough staff to support patients leave arrangements and to have 1:1 with their named nurse. Staff rarely cancelled escorted leave or ward activities.
- Ninety-four percent of staff had attended mandatory training.
- The provider used an environmental risk management plan for the hospital that used a red, amber, green (RAG) rating system. Staff matched patients risk assessments to this plan. Staff and patients we spoke with understood the plan, and what it meant for them.
- Staff were carrying out full physical healthcare examinations as required, and were aware of addressing any specific issues such as pressure sores, and signs and symptoms of potential sepsis.

Are services effective?

Good

We rated effective as **good** because:

- Staff completed separate and comprehensive physical healthcare records for each patient. These records formed part of the morning briefing and two weekly multidisciplinary ward round.
- The provider had introduced a communication form that patients asked their doctors and any other healthcare professionals to complete following appointments. In this way, the hospital staff could support any recommendations for further follow up healthcare.
- Staff provided active smoking cessation, and weight management programs.
- The forensic psychologist provided family therapy as well as one to one therapy, in line with National Institute for Health and Care Excellence guidance.
- Staff assessed patients nutritional and hydration needs, and recorded these needs in the care records. The chef was included in the morning briefing sessions to offer advice and support where staff had identified specific nutrition plans for patients.
- Data provided at the time of inspection showed 95% of staff were up to date with supervision.

Summary of this inspection

- All staff attended a range of in house meetings including daily briefings, community meetings, and integrated governance meetings. We reviewed minutes of these meetings and found issues identified had been actioned.
- Staff demonstrated awareness of Mental Health Act principles and knew where to seek further advice. Staff explained patients' rights in a way they could understand, in accordance with section 132 of the Mental Health Act. Data provided at the time of inspection showed 91% staff had completed Mental Health Act training.
- Data for the period November 2016 to December 2017 showed 97% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguarding training. Staff were aware of their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguarding, and understood how the guiding principles applied to their work roles.

Are services caring?

Good

We rated caring as **good** because:

- Patients and carers told us staff were caring, mindful of their needs, and helpful. We saw staff interacting with patients in a respectful manner and maintained patient's privacy and dignity.
- Following the results of a recent patient satisfaction survey. Managers were in the process of introducing a number of changes including: - the introduction of safety issues being a standard item in weekly key worker discussions. Managers inviting patients to attend operations and governance meetings. Advocacy issues being a standard agenda item at patient community meetings, and the hospital director attending at least one community meeting per month.
- Prospective patients were encouraged to visit Sturdee Community Hospital, meet staff, and ask questions before accepting a placement.
- Patients jointly planned, facilitated and attended the weekly interactive academic teaching sessions with staff on a Thursday morning.
- Patients we spoke with understood their health conditions and knew when and where to seek further help and advice. Staff encouraged patients to make their own appointments with external healthcare professionals as required, and gave necessary support to patients who were not able to do this independently.

Are services responsive?

Good

We rated responsive as **good** because:

Summary of this inspection

- There was a clear admission and discharge policy and procedure. The consultant psychiatrist in discussion with the forensic psychologist, nurses, occupational therapist and social worker oversaw this.
- Staff explained how patients recovery plans helped them to move from the locked rehabilitation Rutland ward to the semi supported flats in Aylestone unit, prior to taking up community placements.
- Key workers and patients jointly formulated initial discharge plans as part of the ongoing patients' recovery focussed work.
- Sturdee Community Hospital had a range of rooms and equipment to support treatment and care. Patients personalised their bedrooms, and had a lockable cupboard to store their possessions.
- Patients personalised their menu plans from a wide range of good quality foods on offer, and catering staff changed this range of food every four weeks. Chefs catered for special dietary requirements, and ensured there were always healthy options available. Staff clearly indicated special dietary information and healthy options on the menu board.
- Staff encouraged patients to maintain their community networks where possible. Section 17 leave, where required, reflected these needs including periods of extended leave to visit family who may not live locally.

However:

- At the time of inspection, the occupational therapist had been on maternity leave, and patients had not had benefit of specialist occupational therapy assessment. This meant that while staff had identified occupational goals in care plans, the detail for achieving these goals was missing. Staff had not specified the motivational work stages, graded activities of daily living and occupational achievement plans.
- Patients reported that some of the planned group activities were not very challenging or meaningful for them, and often limited in variety. Some patients told us that staff had not updated their individual activity plans to reflect their current needs. We also heard how there was limited planned activity available at weekends.

Are services well-led?

Requires improvement

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

- The hospital failed to provide the newly appointed Mental Health Act Administrator with sufficient training, guidance,

mentoring and Mental Health Act systems to ensure that Mental Health Act practice met with the requirements of the Act and Code of Practice. Evidenced by the hospitals failure to refer patients for automatic tribunals.
- The Mental Health Act Administration policy and guidance was out of date and not robust enough to cover the range of Mental Health Act administrators' functions.
- The hospital did not have an effective system to maintain oversight of the delivery its Mental Health Act administrative functions.
- We reviewed the providers' action plans following their last Mental Health Act review visit to Aylestone unit and Rutland ward. We found that staff had not ensured completion of the quarterly external audit of all Mental Health Act paperwork. Senior managers had scheduled audits for April 2017 and July 2017. However, we found only one audit had taken place in April 2017, and at the time of our inspection, staff were not aware of any others being planned.
- Neither Aylestone Unit nor Foxton ward had been included on the ligature audit. Staff had not identified blind spots around the hospital.

However:

- The provider had a clear statement of their vision and values based on growth, recovery, ownership, warmth, time and healing. Staff underpinned this with a philosophy of positive risk taking and least restrictive practice.
- Managers used key performance indicators to gauge the performance of the hospital this included mandatory training, mental capacity act monitoring, managing sickness and absence rates and carrying out clinical audits.
- Managers had successfully addressed their staffing shortfall. They currently met the required number of staff to meet the needs of the patients.
- Staff we spoke with were not aware of any bullying or harassment in recent times, and they felt they worked well as a team.
- Staff were aware of the hospitals whistle blowing policy and told us they felt confident to use it if necessary. There had been no cases of whistle blowing in the last 12 months.
- Managers responded to feedback from previous inspections, complaints, and serious incidents. They had produced several action plans we were able to monitor during the inspection.

Summary of this inspection

- We saw evidence of the changes managers had made, such as improved communication systems, and improved general practitioner and hospital liaison. Managers had revised policy and procedures in response to feedback from incidents, complaints and concerns.

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.

- At the time of the inspection, there were 20 patients at the hospital, and 17 of those patients were detained under the Mental Health Act 1983.
- Staff demonstrated awareness of Mental Health Act principles and knew where to seek further advice. The Mental Health Act administrator carried out audits of Mental Health Act papers to ensure detentions remained legal.
- Staff completed contingency plans prior to patients utilising escorted section 17 leave. This meant that they knew what to do if something untoward happened.
- Staff attached consent to treatment forms to medication cards where necessary to show consent.
- Staff explained patients' rights in a way they could understand, in accordance with section 132 of the Mental Health Act. Patients had access to independent advocacy services, and staff encouraged them to seek support from this service.
- The hospital displayed information on access to independent Mental Health Act advocates on the wards.
- Data provided at the time of inspection showed 91% staff had completed Mental Health Act training. A Mental Health Act administrator was available to offer support to staff.
- However, we found evidence of poor organisational governance for the functions of Mental Health Act administration. Evidenced by the hospital's failure to refer patients for automatic tribunals.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Data for the period November 2016 to December 2017 showed 97% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguarding training, and this training was mandatory.
- Staff were aware of their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguarding, and understood how the guiding principles applied to their work roles; they knew where to get advice regarding Mental Capacity Act and could refer to the policy if needed.
- During the period January 2017 to December 2917, Sturdee Community Hospital had made no Deprivation of Liberty Safeguarding applications.
- Staff completed capacity assessments where required, which were decision specific and filed in patients care notes. There were no best interest meeting records and staff told us they could not recall when the last best interest meeting had taken place.
- However, evidence in the care records showed staff were acting in the best interest of patients. Staff were following requirements of the Mental Capacity Act code of practice.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

- Wards were visibly clean, well maintained and had good quality furnishings. Portable appliance test and maintenance stickers were visible and in date. The infection control policy was in date and staff demonstrated knowledge of infection control principles. Cleaning records were available. Wards complied with guidance on mixed sex accommodation. There were no seclusion rooms at the hospital. Staff used de-escalation strategies in quiet areas of the ward.
- The clinic room on Rutland ward was small but adequate for its purpose as a dispensary. Staff carried out physical health examinations in other suitable rooms on the ward. There was accessible resuscitation equipment available, and staff kept emergency drugs in the dispensary on each ward. Staff regularly checked and calibrated equipment and kept a record of this. Staff checked and recorded the temperature in the clinic on a daily basis.
- The clinic room on Aylestone unit was an unused flat and only used to store medications for patients who were not self-medicating. Staff kept the room locked and held the keys on their person. If patients needed physical examination, staff used the doctor's office.
- Managers had not ensured that the ligature audit was complete, ligatures are places to which patients intent on self-harm might tie something to strangle themselves. Staff had identified the blinds in the gym and sliding door in the corridor on Rutland ward as ligature points, but they had not taken action to reduce these specific risks. Managers had not identified blind spots throughout the service. However, there were convex mirrors in the corridors on Rutland ward.
- There was no ligature audit for Aylestone unit or Foxton ward. The provider considered Aylestone Unit, an independent living and rehabilitation unit, and staff used Foxton ward as a therapy hub; as such, staff always escorted patients in this area. We did not consider this adequate mitigation because both Aylestone and Foxton are registered as part of the hospital, both areas are staffed when patients are using the areas, and both areas can and do accommodate patients who are detained under the Mental Health Act and who could and do present with high risk of ligature and self-harm. However, four weeks after the inspection the provider submitted ligature assessments for Aylestone Unit and Foxton ward, though these assessments have not been corroborated.
- All staff carried personal alarms, which they used to summon help in an emergency. Staff had access ligature cutters, for which they had received training on how to use them safely. There was a patient call bell in all clinical areas.

Safe staffing

- The established level of qualified nurses across the hospital at the time of the inspection was six whole time equivalents. At the time of the inspection, managers were recruiting to two whole time equivalent qualified nurse vacancies and four whole time equivalent healthcare support worker vacancies, but these staff had not started yet.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Baseline staffing was two qualified nurses and four healthcare support workers per daytime shift, plus multi-disciplinary team colleagues including occupational therapists and a forensic psychologist. Overnight staffing was one qualified nurse to four healthcare support workers. Daily nursing rosters confirmed these numbers.
- Staff told us they felt safe working at the hospital and could access additional staff when required, using their own staff bank or known agency staff. Managers discussed staffing levels daily in the briefing meetings and deployed staff to take into account individual patient need and risk.
- Between July 2017 and September 2017, known bank or agency staff had filled 432 shifts to cover enhanced observation levels, vacancies or sickness. However, management explained that during this period they had accepted three new admissions all requiring heightened observation levels for some period, and bringing in additional known temporary staff took the pressure off existing staff.
- Staff turnover at the hospital for the period February 2017 to September 2017 was 11 staff (20%) across all grades. The previous year this figure had been 47%. While staff sickness rates were 6%.
- Sturdee Community Hospital employed its own consultant psychiatrist. The doctor was also available outside of normal working hours and provided an on call duty service alongside another colleague from another hospital within the Inmind Healthcare Group.
- Staff were encouraged to remain visible and on the ward and there was a qualified nurse in the communal areas at all times. There were enough staff to support patients leave arrangements and to have 1:1 with their named nurse. Staff rarely cancelled escorted leave and ward activities, and there were sufficient staff to carry out physical interventions when required.
- Data provided at the time of the inspection showed 94% of staff had attended mandatory training, which included safeguarding adults level one and two, immediate life support, management of actual or potential aggression (MAPA), and infection control. One hundred percent of staff had trained in medicine management. There were no mandatory training figures below 86%, which was for MAPA training.

Assessing and managing risk to patients and staff

- For the period 01 April 2017 to 17 October 2017, there had been 22 incidents of restraint involving five different service users. Staff had not used rapid tranquilisation during this period. One of these restraints had been prone restraint (face down) for the shortest time possible to allow staff to remove a ligature, before the patient was turned. We saw how staff had documented these restraints in the care record including the physical health monitoring and support required following administration of a restraint procedure.
- Daily care notes, completed at the time of any restraint process, evidenced that staff only used restraint after de-escalation had failed and they had used correct management of actual or potential aggression (MAPA) techniques. Use of prone restraint was not encouraged and only occurred either when there were no other options, such as to safely remove a ligature, or when patients went to the floor in a face down position.
- There had been no patient seclusions for the same period, and no incidents of long-term segregation.
- We reviewed fourteen patient risk assessment records. The provider used an environmental risk management plan for the hospital that used a red, amber, green (RAG) rating system. Staff matched patients risk assessments to this plan, and staff and patients we spoke with understood the plan and what it meant for them. For ease of reference, staff recorded individual patients RAG rating on a white board in the nurse's office.
- Before patients went on escorted section 17 leave staff completed contingency plans. This meant that they knew what to do if anything untoward happened.
- There were robust policies and procedures for use of observation (including minimising risk from ligature points). Staff carried out enhanced observations of patients and kept up to date records showing interventions used to engage the patient.
- There was policy and procedure for the searching of patients, their property and their bedrooms. However, following a serious incident in January 2017, there was evidence to suggest that not all staff were carrying out thorough enough searches of patients belongings when returning to the Rutland ward. Managers had addressed this by reinforcing with staff the correct way to carry out personal searches as per their policy.
- There were no blanket restrictions in use at Sturdee Community Hospital. Informal patients could leave the ward at will, but did have to ask a staff member to unlock the main door to the ward.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Data provided at the time of inspection showed 92% of staff had received safeguarding adult's level one and two and children level one training. We saw how staff worked in partnership with other agencies to safeguard people. There was a visiting policy to include children, and a family room was available, which was child friendly.
- There were no reports of discriminatory abuse. There were robust policies in place to prevent discrimination and managers told us they would deal with any incidents of discrimination harshly.
- Staff were carrying out and recording full physical healthcare examinations as required. Staff were aware of addressing any outlier issues such as pressure sores, and signs and symptoms of potential sepsis. As part of their weekly interactive academic sessions, staff had encouraged patients to be more involved in understanding their own physical healthcare needs and using physical wellbeing strategies.
- We reviewed eleven patients' prescription charts. While staff had completed most of the charts correctly, we found one chart where the doctor had prescribed Olanzapine and Lorazepam for a patient but did not reference the need for a two-hour gap in administration.
- It was unclear from the prescription charts when primary medicine reconciliation had occurred, and it was noted that the pharmacist was not involved in this process.
- Although the medicines management policy was in date, we found staff were not following the policy. We saw staff dispensing "to take out" (TTO) medicines to patients in unlabeled bags and containers. The visiting pharmacist had previously identified this as an area of concern and provided a supply of suitable boxes, bags and labels for staff to use. Medication was not recorded or checked by a second person in the dispensing record.
- Staff had removed insulin from the fridge and this was stored and administered from the medication trolley. Staff had not revised the expiry date as recommended and could not ensure that the efficacy of the insulin had been affected.
- Staff had recorded the medicines fridge in the clinic as above eight degrees on 28 occasions during a two month period. On 26 of these occasions staff had not indicated what action they had taken to rectify the situation, on two occasions they had recorded that they had reset the fridge.
- A community-based pharmacist visited the hospital each quarter, we did not consider quarterly visits adequate. While the pharmacist completed medicines management audits and shared these with the ward teams, we feel she may have picked up some of the medication management issues we identified, if she were visiting more frequently.
- Staff ensured the cabinet used for controlled drug storage was securely locked, and only used for this purpose. The contents of the controlled drugs cupboard had been reconciled; staff had completed the controlled drugs register correctly with double signatures throughout.

Track record on safety

- In the last 12 months, the service had reported five serious incidents. Two involved paramedics attending the unit, and two involved patients who had died and one allegation of staff abuse on a patient. There were a further eight incidents of patients needing to be admitted to hospital for treatment following physical health complications.
- We saw examples of how the provider had changed practice, procedure and policy in response to incident outcomes. Including introduction of a deliberate foreign body ingestion policy and procedure. A revised feedback and communication system with local general practitioners, and a second team briefing meeting each day for all those staff who could not attend the multidisciplinary morning handover meeting including chefs, housekeepers, maintenance staff.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to do this. Staff reported incidents using an electronic reporting system. However, we found incident reporting was not fully documented. Not all incident reports indicated what support had been given, or what changes had been made to either the nursing observations or risk rating following the incident.
- Managers had carried out comprehensive investigation of all the incidents and we saw actions taken by the provider in response to those investigations to minimise the risk of similar events happening again.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Senior managers discussed incidents daily in team briefing meetings and shared the management plans with the ward teams to manage any potential risks to patients or staff.
- Senior managers discussed serious incidents at their corporate integrated governance meetings and shared the learning from the investigations across all the Inmind Healthcare Groups' locations. This learning was cascaded down to staff in Sturdee Community Hospital through the recorded daily team briefing, local integrated governance committee meeting and community meetings when appropriate.
- Debriefs were available to staff and patients following incidents.

Duty of Candour

- We saw evidence in the incident outcomes and minutes of various meetings where the provider had upheld their duty of candour, a legal requirement of mental health providers to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.
- Staff were able to describe their duty of candour and the need to be open and honest with patients when things went wrong.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed eleven care records. Staff completed comprehensive assessments for all patients at the point of admission. Care plans were all in date, personalised, holistic, and recovery orientated. Patients signed their care plans and indicated if they wanted a copy or not.
- Care records showed staff undertook and reviewed physical healthcare assessments regularly. These included identification of high doses of anti-psychotic medication prescribed by the doctor, where ongoing monitoring of physical health was required.
- Care records indicated what steps and support patients could expect to help them maintain their own physical and mental wellbeing. Patients were encouraged to be involved in regularly monitoring their own health needs through the weekly interactive academic sessions.
- The provider had introduced a communications form that patients asked their doctors and healthcare professionals to complete following appointments. In this way, the hospital staff could support any recommendations for further follow up healthcare.
- The information needed to deliver care and treatment was stored securely, but remained easily accessible when authorised staff required it. Care records were paper based, orderly and information was generally easy to find.
- Staff supported patients with smoking cessation, and weight management programs.

Best practice in treatment and care

- We found evidence that the hospital followed National Institute for Health and Care Excellence guidance when prescribing medication, managing borderline personality disorder, and managing psychosis and schizophrenia in adults.
- Staff used Health of the Nation Outcome Scales and the recovery star to assess and record severity and outcomes for all patients.
- The forensic psychologist provided family therapy as well as one to one therapy, in line with National Institute for Health and Care Excellence guidance. They also supported staff with debriefing after serious incidents.
- Patients nutritional and hydration needs were met and recorded in the care records, and the chef was included in the morning briefing sessions to offer advice and support where patient specific nutrition plans had been indicated.
- Staff had ensured all patients had registered with a local general practitioner. Managers held regular meetings with the general practitioners they used. Staff referred patients to specialist services for treatment when necessary, for example podiatry and dentistry, and supported them to attend physical health appointments if required.
- Staff carried out a range of audits including, physical health monitoring, care plan audits, medication management, and infection control audits. We found evidence how managers had made improvements following audits.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Skilled staff to deliver care

- Patients received care and treatment from a range of professionals including nurses, doctors, forensic psychologists, occupational therapy technical instructors, and a newly appointed social worker.
- There was an induction and mandatory training program for all new staff including new bank and agency staff, and senior managers monitored this. However, two staff members told us they did not think the induction program was long enough or detailed enough. Staff told us there were long delays to get face to face mandatory training, and there was not always time in the working day to complete the mandatory e learning. This meant staff were completing e learning during their own time. While several of the e- learning modules carried a completion assessment, managers did not follow up with any competency assessment.
- All new and existing healthcare support workers were encouraged to undertake the national care certificate training although this was not a mandatory requirement for Sturdee Community Hospital staff.
- Management supported staff to undertake continued professional development through their weekly interactive academic teaching sessions. Qualified staff were encouraged to take extended scope practice, medication prescribing and leadership programmes. The training policy supported these statements. However, two staff members we spoke with told us training, other than mandatory training and the in house teaching sessions, was difficult to access.
- Data provided at the time of inspection showed 95% of staff were up to date with supervision. Staff confirmed the new supervision matrix introduced in May 2017 had made monitoring supervision much easier. Unlike previous inspection findings staff we spoke with understood the purpose of their supervision and saw this as a positive process.
- Individual supervision records were kept on the staff file and those staff we spoke with confirmed they had been given copies of their supervision notes.
- Data provided at the time of inspection showed 68% of eligible staff had had an annual appraisal. The reason given was that many staff were newly recruited and therefore not due an appraisal.
- Doctors and qualified nurses had completed their revalidation processes when required.
- Managers said they had support to manage poor performance promptly.

Multi-disciplinary and inter-agency team work

- All staff attended a range of in house meetings including daily briefings, community meetings, and integrated governance meetings. We reviewed minutes of these meetings and found issues identified had been actioned.
- All patients' care and treatment needs were reviewed every two weeks in a multidisciplinary team meeting. Patients and their carers were encouraged to attend their meeting and received support by their key worker or advocate as appropriate during the meeting.
- Staff invited community mental health workers, general practitioners, and care coordinators to attend multidisciplinary team meetings. An administrator recorded these meetings and circulated copies of the updated care plans to all relevant persons, including general practitioners and community mental health workers.
- Managers explained how they had engaged in a series of community meetings with police, local service providers, and local councillors to promote integration and positive attitudes towards people with mental health conditions.

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

- At the time of the inspection, there were 20 patients at the hospital, and 17 of those patients were detained under the Mental Health Act 1983.
- Staff showed awareness of Mental Health Act principles and knew where to seek further advice. The Mental Health Act administrator carried out audits of Mental Health Act papers to ensure detentions remained legal.
- Staff completed contingency plans prior to patients utilising escorted section 17 leave. This meant that they knew what to do if something untoward happened.
- Staff attached T2 and T3 consent to treatment forms to medication cards where necessary.
- Staff explained patients' rights in a way they could understand, in accordance with section 132 of the Mental Health Act . Patients had access to independent advocacy services, and staff encouraged them to seek support from this service.
- The hospital displayed information on access to independent Mental Health Act advocates on the wards.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Data provided at the time of inspection showed 91% staff had completed Mental Health Act training. A Mental Health Act administrator was available to offer support to staff.
- However, we found evidence of poor organisational governance for the functions of Mental Health Act administration.

Good practice in applying the Mental Capacity Act

- Data for the period November 2016 to December 2017 showed 97% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguarding training, and this training was mandatory.
- Staff were aware of their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguarding and understood how the guiding principles applied to their work roles; they knew where to get advice from regarding Mental Capacity Act and could refer to the policy if needed.
- During the period January 2017 to December 2917, Sturdee Community Hospital had made no Deprivation of Liberty Safeguarding applications.
- Staff completed capacity assessments where required, which were decision specific and filed in patients care notes. There were no best interest meeting records and staff told us they could not recall when the last best interest meeting had taken place.
- Audits were in place to monitor the providers' compliance with Mental Capacity Act.

Equality and Human Rights

- Data for the period April 2017 to November 2017 showed 94% of staff had completed equality and diversity training, which was mandatory.
- Staff and clients told us they felt respected by each other, and clients said staff were not judgemental of them.
- Policies relating to equality and diversity were in place. All policies contained an equality impact statement. The provider told us they also used the culture of care barometer to collate equality and diversity information. We saw no blanket restrictions at Sturdee Community Hospital.

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

Good

Kindness, dignity, respect and support

- Patients and carers told us staff were caring, mindful of their needs, and helpful. We saw staff interacting with patients in a respectful manner.
- We observed staff undertaking one to one observations in a caring manner and encouraging participation in activities. We observed staff supporting patients to attend activities both on and off the ward.
- Patient's privacy and dignity was being upheld. We saw one distressed patient being encouraged to accompany a staff member, who was offering support, to a quieter and more private place to talk about her distress. We saw notes on the nurses' board where some patients had requested that male staff did not carry out any observations in the bedroom areas of the hospital. Patients were encouraged to attend the medication clinic one at a time to protect any conversations to be had.
- Staff respected patient's confidentiality seeking their permission for members of the inspection team to attend reviews and meetings with them.
- Action plans following a recent patient survey included the following points. The community meeting agenda now included feedback on staff conduct. Weekly key worker sessions included issues of safety. Patients were to be represented in Operations and Governance meetings as from January 2018. Hospital protocols were reviewed with all new patients. Weekly patient community meetings covered advocacy issues, and from January 2018, the Hospital Director would be attending community meetings at least once a month.

The involvement of people in the care they receive

- Prospective patients were encouraged to visit Sturdee Community Hospital, meet staff, and ask questions before accepting a placement.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff actively encouraged patients and their families, if agreed with the patient, to take part in care planning and to attend their fortnightly multidisciplinary meetings. The administrator recorded these meetings for the care record and circulation as necessary.
- There were posters displayed on both wards advising patients how to access advocacy services. The advocate visited the wards regularly to talk with patients.
- Sturdee Community Hospital held formal community meetings once a week for patients from both Rutland ward and the Aylestone Unit. There were also informal breakfast and evening meetings held daily. Staff and patients used these meetings to discuss plans for the day ahead and to review how the previous day had been for the patients.
- Patients jointly planned, facilitated and attended the weekly interactive academic teaching sessions with staff on a Thursday morning. One patient told us how they used any certificates of attendance from these sessions in their portfolio of achievement.
- Patients we spoke with understood their health conditions and knew when and where to seek further help and advice. Staff encouraged patients to make their own appointments with external healthcare professionals as required. When necessary staff supported patients who were not able to make or attend appointments independently.
- We saw how one patient had produced an advance decision document and this was available in their care records.

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

Good

Access and discharge

- The consultant psychiatrist in discussion with the multidisciplinary team ensured they followed a clear admission and discharge policy and procedure. Following referral, patients and their carers were invited to visit the hospital to meet fellow patients and staff. If the patient and their families or carers were happy with the admission, then the team implemented the formal admission process.
- New patients underwent further comprehensive assessment over a period of three to four months to formulate recovery goals and a detailed risk assessment, and to ensure that the hospital could meet the patients mental and physical care needs,
- Data for the period April to October 2017 showed bed occupancy at 75% for Rutland ward and 62% for Aylestone unit. The average length of stay was 330 days, the provider did not think this to be excessive given the complex nature of the client group and how they specialised in slow rehabilitation.
- There was no waiting list for admission to Sturdee Community Hospital. There was no waiting list for access to psychology, which was provided to all patients who needed it at least once one week.
- We heard of one delayed discharge in the six months prior to inspection due to there not being an appropriate community placement for the patient, and one readmission.
- Staff explained how patients recovery plans helped them to move from the locked rehabilitation Rutland ward to the semi supported flats in Aylestone unit, prior to taking up community placements. One patient explained how she had used the opportunities provided by the staff to gain skills and confidence to be more self-sufficient; she said the opportunity to move from Rutland ward to Aylestone unit had been an important step in her recovery.
- Key workers and patients jointly formulated initial discharge plans as part of the ongoing patients' recovery focussed work. The key worker and patient formulated detailed discharge plans, when they had found a suitable community or other placement.

The facilities promote recovery, comfort, dignity and confidentiality

- Sturdee Community Hospital had a range of rooms and equipment to support treatment and care. This included quiet rooms for family visits, activity rooms, therapy rooms and a gym. Patients had access to outside space. Patients had access to individual mobile phones.
- Patients were able to personalise their bedrooms, and had a lockable cupboard to store their possessions.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff and patients formulated programmes of weekly activities at community meetings and morning meetings. Staff displayed copies of the weekly activity programs in main ward areas, and patients had copies of their own specific activity plans, including leave plans and arrangements.
- Staff completed recovery plans reflecting patient's interests and goals that staff had formulated over time. However, at the time of inspection the occupational therapist had been on maternity leave. This meant patients had not had benefit of specialist occupational therapy assessment. Therefore, the detail of how those goals would be achieved was missing. Motivational work stages, graded activities of daily living and occupational achievement plans were not specified.
- Patients reported that some of the planned group activities were not very challenging for them, and often limited in variety. Some patients told us that their individual activity plans were not being updated to reflect their current needs. We also heard how there were limited activities available at weekends.
- Hot and cold drinks and snacks including fresh fruit, were available throughout the day and night.

Meeting the needs of all people who use the service

- There were accessible bathing and toilet facilities on the ground floor for anyone with mobility needs.
- Staff supported patients to access places of worship in the community, and there was provision for patients to invite local faith leaders to attend the hospital if requested.
- The staffed kitchen provided a wide choice of meals for patients. We saw evidence this choice extended to catering for specific dietary requirements. Patients were able to personalise their menu plans from a wide range of foods on offer, and this range of foods was changed every four weeks. Healthy options were available and these were clearly indicated on the menu board. The food hygiene rating as at October 2017 was five indicating very good.
- Patients had been able to access physical occupational therapy assessment, and we saw how, staff had provided patients with specialist equipment to help them be more independent with activities of daily living and personal care.
- We saw leaflets explaining what treatments, medication, and community activities, were available to patients. Leaflets included information explaining patients' rights under the Mental Health Act, and how they could access independent advocacy. Staff told us they could provide this information in different languages and large font as required, and interpreters could be booked as needed.
- Patients were encouraged to maintain their community networks where possible. Section 17 leave, where required, reflected these needs including periods of extended leave to visit family who may not live locally. When required managers booked in additional staff to facilitate these periods of leave without placing undue pressure on those staff remaining on the unit.

Listening to and learning from concerns and complaints

- During the 12 months, leading up to this inspection there had been 14 complaints, made by nine individual complainants. Three complaints had been upheld, five had been partially upheld while six had not been upheld. There had been no complaints referred to the ombudsman. Key themes for complaints included changes of named nurse at short notice, patients in semi supported Aylestone flats no longer being able to purchase food from the Rutland ward kitchen. Staff being abrupt and or rude and not explaining things clearly.
- Patients and carers told us they knew how to make a complaint, and staff told us how they handled complaints in line with hospital policy. We saw evidence of complaints having been investigated and tracked through, including a revised letter of response to complainants that considered the requirements of the provider under their duty of candour.
- Managers gave staff and patients feedback from complaints investigations, as part of either community meetings or integrated governance meetings. However, some staff we spoke with told us they did not seem to receive very much feedback at all, while another staff member told us they got too much information.
- We saw evidence of managers having escalated complaints to organisational board level for cross service discussion and learning lessons. Managers had subsequently brought the learning from these meetings back to Sturdee Community Hospital.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

Requires improvement

Vision and values

- The provider had a clear statement of their vision and values based on growth, recovery, ownership, warmth, time and healing. This was underpinned by a philosophy of positive risk taking and least restrictive practice. We saw posters around the hospital explaining these values and staff demonstrated knowledge of the values. Team objectives, changes in the service, and feedback from incidents and complaints reflected the vision and values of the hospital.
- Staff and patients told us they knew who the senior managers were and frequently saw them on the ward. Senior managers told us how they sometimes covered the ward areas for a period in the morning to allow all staff to attend team briefings. Both patients and staff said they felt comfortable approaching senior staff to discuss any concerns.
- The provider had a business strategy that met the requirements of commissioners and wider local healthcare needs. The provider had service contingency plans, should they be required in an emergency.

Good governance

- Managers used key performance indicators to gauge the performance of the hospital this included mandatory training, Mental Capacity Act monitoring, managing sickness and absence rates and carrying out clinical audits. This information was stored on spreadsheets, and authorised personnel could access and update the spreadsheets when required.
- Managers had successfully addressed their staffing shortfall. Staff were encouraged and enabled to maximise shift time on direct care activity, as opposed to administration tasks.
- Managers reviewed and signed off actions from incidents. The senior staff team fed-back the outcomes of the investigations to other staff at team briefings and the integrated governance meetings.
- Staff said they generally felt supported by senior managers, and had sufficient authority to make prompt changes. For example by increasing staffing levels to meet the enhanced observation needs of patients.
- Managers reviewed the risk register monthly to address the identified issues. Staff said that they could raise issues at ward level for inclusion in the hospital risk register. There were clear two-way communication systems between ward level, hospital level and board level.
- Ninety percent of staff had up to date supervision. The provider had robust systems for recording and monitoring supervision.
- While audits were in place, for infection control, controlled drugs, and care planning, and most of the actions from previous inspections had been completed. The audits relating to medication management had not picked up some significant issues, and neither Aylestone Unit nor Foxton ward had been included on the ligature audit.
- We reviewed the providers' action plans following their last Mental Health Act review visit to Aylestone unit in March 2017 and Rutland ward in September 2017. We found that all actions had been completed with the exception of the proposed quarterly external audit of all Mental Health Act paperwork. Audits had been scheduled for April 2017 and July 2017, however, we found one audit had taken place in April 2017, and at the time of our inspection, staff were not aware of any others being planned.
- Neither the hospital nor the organisation had effective systems to maintain oversight of the delivery of its Mental Health Act administrative functions. We found the hospital had failed to provide Mental Health Act administration staff with sufficient training, guidance, and mentoring to carry out all the functions required under the Act and Code of Practice.
- The organisation did not have adequate systems in place to ensure that all Mental Health Act functions met with the requirements of the Act. Evidenced by the hospital's failure to refer patients for automatic tribunals.
- The organisations Mental Health Act policy was out of date and not wide ranging enough to cover the range of Mental Health Act administrators' obligations as detailed in the Mental Health Act code of practice. The policy being used by the mental health act administrator was dated November 2014 and marked

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

for review in 2016. However, on the last day of our inspection we were presented with a Mental Health Act Manual written in September 2017. Staff we spoke with had not been aware of this manual.
- We sampled 15 staff files and found all had up to date disclosure and barring services (DBS) documentation in place.

Leadership, morale and staff engagement

- Data for the period July 2017 to October 2017 showed overall sickness rates to be 6%. Managers told us this was about average for their service.
- Staff said there had been a lot of change over the last six months, they felt management were more prepared to listen to them and staff morale was good. Staff understood the need for being open and honest with patients, colleagues, and carers when anything went wrong.
- Staff we spoke with were not aware of any bullying or harassment in the 12 months prior to this inspection, and they felt they worked well as a team. There were opportunities for staff to engage in further development, though one staff member we spoke with told us accessing further training was sometimes difficult.
- Staff were aware of the hospitals whistle blowing policy and told us they felt confident to use it if necessary. There had been no cases of whistle blowing in the 12 months prior to this inspection.
- Staff we spoke with said they were proud of what they and Sturdee Community Hospital had achieved in the previous six months, and they felt confident moving forward with the new hospital director and the senior management team.
- The review of training needs across the organisation, introduction of more flexible e-learning modules and new monitoring systems had a positive impact on staff training figures. However, three staff told us they did not have time in their working day to complete all the required e learning, and were using their own time, unpaid, to do this.

Commitment to quality improvement and innovation

- Sturdee Community Hospital was not part of any national service accreditation scheme or peer review scheme. Though managers explained this was something they would be considering in the future.
- Managers explained how the organisation expected all hospital directors in the group to have identified quality improvement plans. Minutes of meetings showed managers discussed improvement plans at board level every quarter, and management monitored progress of the plans through corporate governance meetings.
- Managers told us they had worked hard over the last year to respond to feedback from previous inspections, complaints, and serious incidents, and acknowledged that they still had further actions and plans to be developed and embedded in practice. They had produced several action plans we were able to monitor during the inspection.
- Managers had strengthened their management structure, by introducing the roles of safeguarding lead, and health and safety leads, and were making more effective use of their organisations training manager.
- We saw evidence of the changes managers had made, including improved communication systems, improving their general practitioner and hospital liaison. Revising policy and procedures in response to feedback from incidents, complaints and concerns. We saw evidence of them promoting positive physical health care and education amongst both patients and staff.
- The service had a culture of wanting to provide high quality sustainable care for the specific patient group they served. This included the appointment of a physical healthcare lead, separate clinical nurse lead and defined responsibility for safeguarding, human resources, and Mental Health Act administration.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the ligature audit for Sturdee Community Hospital is completed and accurate.
- The provider must ensure that blind spots across Sturdee Community Hospital are identified and mitigated.
- The provider must ensure that the medicines management policy is adhered to and includes safe prescribing, administration and storage of medications.
- The provider must ensure that they have adequate oversight to ensure delivery of it's Mental Health Act administration functions.

Action the provider SHOULD take to improve

- The provider should ensure that all incident reports include records of any actions taken or changes to policy and procedures.
- The provider should ensure that all patients have detailed occupational therapy plans that meet the patients motivational, social, and independent living skills needs.
- The provider should ensure that they have adequate pharmacist monitoring.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The ligature audit for the hospital was incomplete. There was no ligature audit for Aylestone unit or Foxton ward.The provider had not identified the blinds in the gym and the sliding door in the corridor on Rutland ward. The environmental risk assessment did not identify the blind spots throughout the hospital. • The take out medicines policy was not being followed. The medicines fridge was recorded as above eight degrees on 28 occasions in a two-month period. Insulin was being used off the trolley after the advised expiry date. This was a breach of regulation 12 (2) (a) (b) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The hospital did not have an effective system to maintain oversight of the delivery of its Mental Health Act administration functions. • The provider's Mental Health Act policy was out of date and not sufficiently detailed to cover the range of Mental Health Act administrator's obligations. • The hospital failed to provide the new Mental Health Act administrator with sufficient training, guidance and mentoring to carry out her functions. • We found that the proposed quarterly external audit of all Mental Health Act paperwork had not been actioned.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 17(1)(2) (a)