Clifton Hospital

Quality Report

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Date of inspection visit: 15 & 16 August 2018
Date of publication: 19/10/2018

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
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 Cygnet Hospital Clifton as requires improvement because:

- Staff did not always treat patients with kindness and compassion. This was confirmed in interviews with patients and our review of hospital records. We frequently saw staff responding to patients requests for assistance, rather than approaching patients to initiate contact and support.
- Staff practices did not ensure that risks to patients were always minimised. This was demonstrated in failures to maintain checks of emergency equipment, undertake prescribed observations, and monitor patients following the administration of rapid tranquilisation.
- Communication practices were poor. This was confirmed in interviews with staff and patients. We saw an example of how information poorly communicated between staff led to gaps in care. Patients reported that staff did not keep them informed of changes occurring in the service and inform them of planned visitors to the wards.
- Staff did not always keep accurate and complete records of the care and treatment provided to patients. This included patients being cared for in seclusion.
- Staff reported short staffing, low morale, and an unhappy staff team. Staff were concerned about high staff turnover rates, the suitability of training provided for their roles, and maintaining professional staff and patient boundaries. Patients reported experiencing delays when they required staff support to move around the hospital.
- Staff completion rates for Mental Health Act and Mental Capacity Act training were low. Some staff identified a need to receive training in these areas, and others believed the training offered was not sufficient for their roles.
- Management systems were not embedded to ensure that all staff were aware of, and understood lessons learned as the result of the investigation of incidents and complaints. Staff reported their experience of this was poor, and examples of good practice were not embedded in the service.
- Despite the new providers improvement plan, transition to existing governance structures, and additional senior and multi-disciplinary staff, change at the service had not sufficiently embedded to demonstrate safe and effective care.

However:

- There was evidence of investment into the service from the new provider. This included changes to the hospital environment to improve safety, establishing a new senior staff team, the recruitment of additional staff, and an overarching action plan of improvement in all clinical areas.
- Staff completed risk assessments for the hospital environment and individual patients. Resulting plans from these assessments contributed to reducing restrictive practices for patients.
- Staff assessed the physical and mental health of all patients on admission. Interviews with patients confirmed that staff supported them with their physical health and encouraged them to live healthier lives.
- Staff supported patients to access activities inside and outside of the hospital. This included voluntary work, education, and community support for patients with protected characteristics. Patients could also contribute to decisions about the service by contributing to staff recruitment practices and a People's Council.

Summary of findings

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Requires improvement

Cygnet Hospital Clifton

Services we looked at
Forensic inpatient/secure wards;

Summary of this inspection

Background to Clifton Hospital

The Cygnet Hospital Clifton is a specialist low secure mental health and rehabilitation service for men with a personality disorder. Patients may also present with complex mental health needs, and challenging behaviours. The hospital has two wards, both can accommodate up to 12 patients. Ancaria ward is the assessment and initial treatment ward; it offers a defined pathway through to Acorn ward which has a focus on rehabilitation. All patients are detained under the Mental Health Act 1983. When we inspected the hospital had 20 patients, nine on Ancaria ward and eleven on Acorn ward.

In April 2018, Cygnet Healthcare had taken over as the registered provider of CQC regulated activities. The service had recently appointed a new hospital manager who had applied to be the CQC registered manager.

Cygnet Hospital Clifton is registered with CQC to provide the 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

The CQC had previously inspected this service in October 2012, March 2013, October 2013, July 2015, April 2016, and November 2016. Following the inspection in April 2016, requirement notices were issued in relation to Regulation 15 (premises and equipment) and Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The requirements under these notices had been met when we re-inspected the service in November 2016.

From May 2014 to present, there has been four Mental Health Act reviews of the hospital. The last review was in November 2016 on Acorn ward. Concerns included staffing levels, the condition of furnishings, seclusion records did not meet Mental Health Act Code of Practice requirements, and consent to treatment records lacked detail of the discussion between the doctor and the patient. The provider submitted an action statement to CQC detailing how they planned to address the concerns raised. During this inspection, concerns remained in some of these areas.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one CQC assistant inspector and one specialist advisor who was a nurse with experience of low secure and rehabilitation services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

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

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

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- collected feedback from seven patients using comment cards
- spoke with three family members or carers
- spoke with the hospital manager
- spoke with 13 other staff members; including doctor, nurses, occupational therapist, psychologist and support workers
- attended and observed one multi-disciplinary hand-over meeting
- looked at eight care and treatment records of patients
- carried out a specific check of the medication management on both wards and reviewed the medicines charts of nine patients
- obtained feedback from one NHS England commission manager
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us they did not feel all staff respected and cared about them. Patients raised concerns about some staff behaving inappropriately, for example, by swearing. Patients told us they found it hard to develop rapport with staff due to the high staff turnover and use of agency staff. Patients told us they did not feel involved in and or informed about changes made to the service, for example, when the provider introduced new polices. However, patients told us the quality and variety of food at the hospital was good. Patients told us staff responded quickly to incidents on the ward and that they felt safe from other patients on the wards.

Carers told us they found staff polite, respectful and caring. However, the carers found that the visitors room was not a nice environment and they wanted to see changes made to it. Carers told us they knew how to make a complaint and were confident they could raise issues. One of the carers we spoke to told us staff kept them informed of changes to their family member's medication and physical health.

We obtained feedback from one NHS England commission manager. They reported historical and current concerns about the service. Historical concern included bullying and harassment of patients from staff, however they believed senior management had acted to address this. Current concerns include a lack of structured psychological treatments offered to patients, failing to report incidents correctly to external organisations, poor communication between staff and patients, and how new members of staff will be supported and trained to work professionally with patients and maintain boundaries. The commissioning manager believed the service to be in the process of change and development following the change of provider.

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:

- Staff did not ensure that all clinical equipment was clean and maintained safely for patients use. This included making failing to make regular checks of emergency equipment, and not cleaning portable examination equipment.
- Staff observation practices were not in line with best practice, and did not minimise risks to patients. This included monitoring patient's physical health after the administration of rapid tranquilisation.
- Staff did not always keep accurate and complete records of the care and treatment provided to patients. This included patients being cared for in seclusion, and observation records.
- Staff experience of receiving feedback from the investigation of incidents was poor. Management systems were not embedded to ensure that all staff were aware of, and understood lessons learned as the result of the investigation of incidents.
- Incidents resulting from staff omissions in care had been escalated to the local authority as safeguarding concerns.

However:

- The hospital manager had reviewed staffing levels. This had created additional vacancies across the hospital, and increased the number of qualified nurses on site each shift.
- The provider was investing in the hospital environment to improve safety. There was a programme in place to make improvements to ward furnishings and decoration.
- Staff completed regular environmental risk assessments that included ligature risk assessments. The service had established security practices and staff had access to working alarm systems. Planned safety improvements to the service included increased staffing, and changes to security and alarms.
- Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually. This included individual plans to prevent the use of restraint and prescribed medication to manage violence and aggression.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of this inspection

- Communication practices were poor. Information poorly communicated between staff at handovers had caused gaps in care that had led to untoward incidents involving patients. The service had not always made the relevant notifications to external organisations.
- Staff completion rates for Mental Health Act and Mental Capacity Act training were low. Some staff identified a need to receive training in these areas, and others believed the training offered was not sufficient for their roles.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and updated them when needed.
- Staff provided treatments and care for patients based on national guidance. Staff supported patients with their physical health and encouraged them to live healthier lives.
- Staff supported patients to make decisions on their care for themselves. The provider had a policy on the Mental Capacity Act to guide practice, and staff assessed and recorded capacity clearly.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Staff did not always treat patients with kindness and compassion. This included not always respecting patients' privacy, and maintaining information confidentially.
- Communication between staff and patients was not always good. We saw staff only responding to patients request for help rather than approaching them to initiate support. Patients reported staff did not keep them informed of changes to the service.
- Records did not demonstrate that staff shared copies of care plans with patients.

However:

- Patients could get involved in making decisions about the service. This included recruitment, a People's Council, and governance meetings.
- The hospital had initiatives to involve family and carers. This included a carer's forum, events, and feedback forms.

Are services responsive?

Good

We rated responsive as requires improvementgood because:

Summary of this inspection

- Staff supported patients with activities outside the service, such as voluntary work, education and community groups.
- Patients had their own rooms where they could keep personal belongings safely. There were quiet areas for privacy and where patients could be independent of staff.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, and treat patients were in line with good practice.

However:

- Patients reported long delays when they required staff support to access activities, fresh air, or support when returning from leave.
- The service did not have a dedicated space for multi-faith worship.
- There were no established practices to share lessons learned from complaint investigations with staff.
- Staff did not always create discharge plans with patients.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The transition to a new provider's governance framework and their improvement plan for the service had not been fully implemented and embedded to demonstrate significant improvement at the service.
- Staff reported short staffing, poor communication, low morale, and an unhappy staff team at the hospital. This was reflected in the service's recent staff survey results.
- Staff and patients raised concerns about the confidentiality of personal information, and we saw an example of staff not storing documents securely.

However:

- The newly appointed hospital manager and senior staff had the right skills and abilities to run the service. This included supporting staff to provide high-quality sustainable care.
- The provider had established vision and values that had been developed with the contribution of staff from other locations. The provider was investing in this service to improve the quality of care.
- The provider was implementing systems for identifying clinical risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Staff reported positive changes occurring because of these changes.

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.

The provider made Mental Health Act and Code of Practice training available to staff as, part of mandatory training requirements. At the time of our inspection, only 45% of eligible staff had received training. Registered staff, including nurses, demonstrated an understanding of the Mental Health Act, its Code of Practice and guiding principles. Nursing assistants demonstrated some understanding, but felt the Mental Health Act and Code of Practice training offered was not sufficient for their roles.

The hospital employed one whole time equivalent member of staff to provide administrative support on the implementation of the Mental Health Act and its Code of Practice. In addition, the hospital held a contract with an external organisation who could provide legal advice when needed. Staff knew who their Mental Health Act administrator was.

Staff stored Mental Health Act paperwork securely. Original documents were kept in the Mental Health Act administrator's office and copies were on wards, filed in patients' care records. Mental Health Act administrators monitored adherence to the Mental Health Act.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Policies and procedures reflected the most recent guidance available. Staff accessed policies online and a copy of the Code of Practice was at the hospital.

Staff provided information to patients in line with section 132 of the Mental Health Act. Staff explained to patients' their rights under the Mental Health Act and made information leaflets available. Staff recorded in care records when this had been completed.

Staff risk assessed patients prior to them taking Section 17 leave (permission for patients to leave hospital) when this had been granted. We saw examples of changes to Section 17 leave when patients had not adhered to the conditions of leave.

Staff adhered to consent to treatment and capacity requirements. This meant that nurses administered medicines to patients under the right legal requirements.

Staff reported that Section 117 aftercare meetings took place for patients who had been subject to Section 3 of the Mental Health Act or equivalent Part 3 powers authorising admission to hospital for treatment. These meetings identified aftercare services to be provided for relevant patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital made Mental Capacity Act training available to staff, as part of mandatory training requirements. At the time of our inspection, only 45% of eligible staff had received training. Registered staff, including nurses, displayed a good understanding of the Mental Capacity Act and particularly the five statutory principles. Staff with a poorer understanding identified the need to have training.

The provider had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards. Staff knew where to get advice regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. This included accessing the policy and speaking to Mental Health Act administrators or senior clinical staff in the hospital.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. Records demonstrated that staff made and recorded capacity assessment for significant, specific decisions including the capacity to consent to treatment.

Records showed that, for patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. This was done on a decision-specific basis regarding significant decisions. Staff met and discussed when a patient's capacity was in question.

Detailed findings from this inspection

When patients lacked capacity, records showed how staff made decisions in a patient's best interests, recognising the importance of the person's wishes, feelings, culture and history. Records showed that staff organised case conferences involving all professionals, advocates, families and carers to inform decisions about patient care.

Mental Health Act administrators monitored adherence to the Mental Capacity Act. This included regular audits. Staff included discussions about the Mental Capacity Act at integrated governance meetings.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

- Access from reception to the hospital environment was through air-lock doors. Air-lock doors consist of a small chamber between two locked doors, the locked both sets of doors cannot be opened at the same time. Both wards were locked and doors throughout the hospital were locked. Staff used keys to move around the hospital, locking and unlocking doors as they went. The provider was introducing electronic 'fob' access that would reduce staff need for keys when moving around the hospital. The hospital manager reported that this would be operational by September 2018.
- Staff obtained and signed for hospital keys from reception at the start and finish of shifts. We saw that staff kept keys firmly attached to them using belts and or pouches. The hospital manager had ordered additional pouches for staff to use as the preferred method for keeping keys safe. to promote staff use of them.
- The provider had security policies and procedures in place to guide staff. Staff were aware of these and knew how to access them.
- Daily ward staff allocated a daily-designated security person to monitor and carry out security procedures. Security handovers took place between shifts. The provider made a security induction All new staff were provided new staff with a security induction.
- The provider had closed circuit television cameras installed in communal areas of the wards and hospital. The camera monitors were in the reception area and were not actively monitored. Staff could use camera recordings as evidence in the review of incidents. The hospital manager described a business plan to increase the number of closed circuit television cameras in operation at the service. They planned to use camera recordings for assurance that staff completed prescribed observations correctly.
- Staff completed environmental risk assessments regularly. This included daily ward environment checks, ligature risk assessments, building risk assessments and fire audits. Ligature points are fixtures to which people intent on self-harm might tie something to strangle them self.
- Ancaria ward was located at ground floor level and Acorn ward at first floor level. Both wards shared the same layout. There were blind spots created by the angles of corridors on the wards. Staff placement and observations reduced risks created by these. Staff supervised shared patient areas around the hospital when in use and locked them when not in use. This included therapy rooms, information technology room and a gym. The hospital had two visiting rooms, one of which had access to a secure outside area.
- All bedrooms are were en suite so each patient had a private shower, wash basin and toilet. There were also communal toilets and bathrooms on each ward.
- The provider completed annual ligature risk assessments. Where ligature risks were identified, we saw resulting actions to manage the risk. This included staff observations and individual risk assessments. Staff kept areas of greater ligature risk locked and supervised patients when they accessed these areas.

Requires improvement

Forensic inpatient/secure wards

- The hospital accommodated only male patients. This complied with national guidance about, and expectations governing the provision of single sex accommodation.
- Patient bedrooms and bathrooms had anti-barricade doors to prevent holding, barring and blocking. Staff received training on anti-barricade mechanisms at induction. Bedrooms doors had observation panels that could be operated externally by staff when making observations.
- Staff had access to personal alarms, and a fixed-point call system was present throughout the hospital and in patients' bedrooms. During the inspection, we saw all staff carrying personal alarms and responding to alarm calls from around the hospital. Arrangements were in place to check both alarm systems. The provider was updating the hospital's personal alarm system to one that would locate and inform staff of exactly where assistance was required. The hospital manager reported that this would be operational by October 2018.

Maintenance, cleanliness and infection control

- Both wards appeared clean. Ancaria ward had several broken and boarded up doors and windows. Staff reported that this had followed recent patient incidents. There was a programme in place to make improvements to ward furnishings and decoration on Ancaria ward. The service employed two whole time equivalent maintenance staff who contributed to an on-call rota.
- The hospital did not participate in Patient Led Assessments of the Care Environment (PLACE) scheme.
- The service employed four whole time equivalent housekeeping staff. Housekeepers worked there seven days a week. Cleaning records for the hospital were present and demonstrated regular cleaning. Where omissions were present, staff had accounted for the omission. For example; when a member of housekeeping staff was working alone. The head of hotel services supervised housekeeping staff.
- Staff adhered to infection control principles including hand washing. We saw posters demonstrating correct hand washing techniques located at sinks around the hospital. Hand gel dispensers were located throughout the hospital.

Seclusion room

- The hospital had a seclusion facility that accommodated one patient. This was accessed directly from Ancaria ward. The facility had a toilet and wash basin, a clock that was visible to patients from within the room, access to a secure outside space, and an externally controlled heating system. An intercom system that allowed for communication when the door was locked was present but not working. Staff reported this had been reported to maintenance for repair. However, we saw communication was still possible between a patient in seclusion and staff. The hospital manager described a plan for a new seclusion facility that could accommodate up to two patients.
- In our review of two seclusion records, we found inconsistencies present in one care and treatment record. This included staff not accurately recording when the seclusion of a patient had commenced and, conflicting professional accounts of why the patient remained in seclusion.

Clinic room and equipment

- Both ward clinic rooms were visibly clean, tidy and well ordered. Clinic checklist and cleaning records were present but did not demonstrate that staff acted daily. We found two omissions present in July 2018 on Ancaria Ward, and nine omissions in July and August 2018 on Acorn Ward. Clinic records did not prompt staff to complete and record cleaning of portable examination equipment.
- Staff on both wards had access to examination equipment necessary for carrying out physical health checks. Staff recorded when equipment, including weighing scales and automated external defibrillators, had last been checked for accuracy.
- Staff made daily checks of clinic room and medicine fridge temperatures. Staff recorded the actions they took to safeguard medicines when room or fridge temperatures went above recommended safe ranges. The quality and effectiveness of medicines can be damaged affected by changes in storage temperatures.
- Emergency grab bags including oxygen, and an automated external defibrillator were stored securely in locked ward offices. This was because not all ward staff had immediate access to the clinic room. Records on Ancaria ward showed that staff checked all emergency equipment weekly in accordance with local policy guidance. However, records on Acorn ward did not demonstrate this. Weekly checks of the emergency grab

bag and oxygen had been made on only seven occasions since April 2018 and the last recorded check was 10th July 2018. In a patient emergency, staff could not ensure equipment was available, or maintained safely for use.

Safe staffing

- The hospital had an established staffing analysis and minimum staffing level document that had been in place since May 2016. In July 2018, following a review of staffing, the newly appointed hospital manager presented a business case for change in the number of staff and organisational structure. This had been approved by the providers operations manager.
- The new organisational structure had created additional staff roles. This included a deputy hospital manager, two clinical team leaders, and an additional therapy co-ordinator post. When we inspected, only the therapy co-ordinator post had been recruited to. The hospital had a rolling programme of recruitment in relation to other vacancies.
- The total number of substantive whole time equivalent qualified nurses was 10. The hospital had four whole time equivalent qualified nurse vacancies. Additional nurse vacancies had been created following the staffing review and organisational restructure.
- The total number of substantive whole time equivalent nursing assistants was 32. The hospital had 10 whole time equivalent nursing assistant vacancies.
- Between 1 April and 30th June 2018, bank staff filled 360 shifts to cover staff sickness, absence, vacancies, or enhanced observations of patients. This accounted for 11% of shift during this period. The hospital reported no use of agency staff during this period.
- Between 1 April and 30th June 2018, the hospital reported that 28 shifts had not been filled by bank or agency staff where there was sickness, absence, vacancies, or enhanced observations of patients.
- The staff sickness rate in the last 12 months was 5.5%. This was higher than the NHS average of 4.8%.
- In the same period, the hospital had a 40% turnover rate for all staff leavers. The hospital's risk register identified high numbers of staff leaving in the probation period of their employment. The provider planned to address staff turnover and retention rates with a new induction and training package.
- Staff worked two shifts to cover the 24-hour period. Staffing numbers during the day were one qualified nurse and four nursing assistants for Ancaria ward, and one qualified nurse and three nursing assistants for Acorn ward. Staffing numbers during the night remained the same as those during the day. Following the staffing review, it had been agreed to increase the number of qualified nurses on site to three per shift.
- Senior management staff and members of the multidisciplinary team worked during the day Monday to Friday and were supernumerary to ward staffing numbers. Senior and multidisciplinary staff reported that they were sometimes asked to assist on wards to maintain patient safety, or assist to facilitate patient's approved leave. However, some multidisciplinary staff also reported that they had been asked to assist nurses in maintaining patient care and treatment records, including care planning.
- The hospital manager reported that actual staffing levels sometimes did not meet planned levels. This was because of absences notified at short notice, including staff sickness or staff cancelling shifts. The hospital manager reported that attempts would be made to cover these absences and safe staffing levels were always maintained.
- The hospital manager could adjust staffing levels daily to take account of case mix. The hospital had introduced a daily morning meeting where senior and multidisciplinary staff met to discuss staffing levels and identified where staff moves were required to cover patient activity.
- The hospital manager reported they could use bank or agency nursing staff to maintain safe staffing levels. Staff did not identify budgets as a barrier to safe staffing.
- The hospital manager had access to its own, and regional bank of nursing staff. The hospital held a contract with two local nurse agencies and where possible only used agency staff that were familiar with the hospital. Staff attempted to fill shifts with bank staff before contacting the nurse agency. All agency staff received an induction prior to working on wards. Bank and agency staff were required to attend handovers at the start of a shift, and each ward had a patient profile book available to staff. These were intended to inform staff of individual patient's needs. However, staff reported that the book was not regularly updated and did not include the details of the most recently admitted patients.
- Qualified nurses were present on the hospital site at all times. However, staff reported occurrences when a ward

might only be staffed by nursing assistants. This included when qualified nurses attended the morning meeting, or to dispense medicines that required two qualified nurses to be present. Staff carried radios to maintain communication when a qualified nurse was not present on the ward.

- Both the hospital manager and hospital's action plan identified a need for improvement in patients having regular one-to-one time with named nurses. This also formed part of the staffing review which had resulted in staffing changes and an increase in the number of nurses each shift.
- Staff reported that staff shortages often resulted in the cancellation of escorted patient leave. However, patients told us staff always tried to facilitate leave and if leave was cancelled staff explained the reasons for this.
- Staff reported that staff shortages often resulted in the cancellation of patient activities. Patients reported that activities did not happen regularly. The hospital manager reported few patients met the agreed 25 hours of meaningful activity each week. The hospital's action plan acknowledged this and set a target for the hospital to reach and maintain. This also formed part of the staffing review which had resulted in staff changes and increased therapy co-ordinator provision.
- Staff we spoke with frequently reported the hospital was frequently short staffed. This meant that they were not able to take breaks during a shift. The hospital manager reported a history of staff overbooking and poorly co-ordinating patient leave and activities. They believed this led to an impression of staff feeling busy and short staffed. To address this the hospital manager had recently introduced a daily planning document to ensure achievable and co-ordinated leave and activity levels in the hospital. However, staff felt this practice was not yet routine and planning of achievable activity levels remained poor. Some staff were aware of the recent staffing review and believed that the changes being made were positive.
- Staff reported they called for assistance from other areas of the hospital when additional staff were needed to assist in physical interventions. This included restraints, observations or seclusion. Staff reported that staffing numbers could sometimes lack staff trained in the management of actual or potential aggression training. However, records showed that 97% of eligible staff had received this training.

Medical staff

- The hospital employed one whole time equivalent consultant and one whole time equivalent staff grade doctors, both contributed to an overnight on-call rota cover Monday to Thursday. The hospital employed two additional forensic consultants who took turn to provide on-call cover between 5pm Friday and 9am Monday. Both were familiar with patients at the hospital and the consultant provided a handover prior to on-call cover commencing.

Mandatory training

- The provider made mandatory training available to all staff. The provider monitored completion rates and reported on them as part of key performance indicators. The hospital had an overall completion rate of 95%. This was above the local target of 85%. Mandatory training covered nine areas including health and safety, safeguarding, and equality and diversity.

Assessing and managing risk to patients and staff

- We reviewed eight care and treatment records. All demonstrated that staff completed a risk assessment of every patient on admission. Records also showed that staff updated risk assessments regularly and following incidents.
- Staff used recognised risk assessment tools, including the Short-Term Risk Assessment and Treatability tool and the Historical, Clinical Risk assessment. The Short-Term Risk Assessment and Treatability tool considered a number of risk categories including violence, self-harm, substance misuse, self-neglect and vulnerability. The Historical, Clinical Risk assesses a patient's probability of violence.

Management of patient risk

- Staff were aware of specific risk issues like falls and pressure sores. Staff assessed patient's mobility and skin condition as part of a physical health assessment on admission. Staff escalated concerns to the staff grade doctor or general practitioner. We observed a multidisciplinary staff discussion specifically about a patient's experience of falls. The discussion was thorough and identified actions to manage the patient's presentation.
- Staff identified and responded to changing risks to, or posed by, patients. Staff did this through observations

and knowledge of patients. Staff escalated concerns to senior staff. Senior and multidisciplinary team staff discussed and reviewed patients risk at the daily meeting. The service provided staff with training specific to security and managing changing risks at induction and as part of management of actual or potential aggression training for staff.

- The provider had an engagement and observation policy and procedure to guide staff practice. The hospital's action plan identified that all staff would have observation and engagement training by the end of September 2018.
- Staff recorded the observations of patients prescribed hourly checks on a pre-printed chart. The format of the chart did not allow staff to record the observation as it occurred, and did not prompt staff to make observations at random times within an hour. Staff used a high-level observation chart to record checks of patients prescribed more frequent observations. Records showed that staff recorded checks only at the prescribed intervals and not at random times within the prescribed intervals, increasing the risk of patients' harming themselves. These practices were not in line with the provider's engagement and observation policy and procedure. In addition, the high-level observation chart did not make it clear which staff member had completed the check, and signatures to confirm the completion of checks were often missing. This meant that records did not always confirm that staff had maintained prescribed patient observation levels.
- The provider had policies and training in place to guide staff practice when searching patients. Staff individually assessed the need to search patients, and recorded this in care plans.
- Patients told us they sometimes had to wait a long time for staff to search them. Staff searched patients when they returned from section 17 leave and after seeing visitors. Staff also searched any items visitors gave patients. The hospital had appointed a security lead who was training staff in conducting patient rub-down searches. Staff used a private room away from the ward to do searches. Where possible, male staff searched patients. When males were unavailable, two female staff searched patients.
- Staff applied blanket restrictions on patients' freedom only when justified. Blanket restrictions are the restrictions on the freedoms of patients receiving mental healthcare that apply to everyone rather than being based on individual risk assessments. The service had a list of items that could not be brought onto hospital premises under any circumstances, and a list of restricted items that patients could access following individual risk assessment and the agreement of the multidisciplinary team. We saw individual patient risk assessments to access restricted items, and lockers were available at reception for the safe storage of these.
- The provider had implemented a smoke-free policy and staff made nicotine replacement therapy available to patients on prescription when needed. Where possible, staff encouraged patients to access community smoking cessation support.

Use of restrictive interventions

- Between January and June 2018, the hospital reported 12 incidents of use of seclusion. All incidents of the use of seclusion had occurred on Ancaria ward. When we inspected Ancaria ward two patients had been subject to the use of seclusion, one of which was being secluded in their bedroom area. The provider had a policy and procedure for seclusion and long-term segregation. Staff reported that seclusion and long-term segregation was rarely used and used only as a last resort to maintain safety.
- Between January and June 2018, the hospital reported no incidents of long-term segregation.
- Between January and June 2018, the hospital reported 20 incidents of the use of restraint relating to three patients. All incidents of the use of restraint had occurred on Ancaria ward. Staff reported that restraint was rarely used. Of the 20 incidents of the use of restraint, two had resulted in the use of prone (facedown) restraint. Both incidents had occurred on Ancaria ward and resulted in the use of rapid tranquilisation.
- The provider had a rapid tranquilisation policy and procedure available to guide staff. The policy referenced guidance on practice from the National Institute for Health and Care Excellence and Maudsley Guidelines. However, we saw a recent example of when staff had failed to monitor and record patient observations following the administration of rapid tranquilisation by injection. This was not in accordance with policy guidance and increased the risk to patients.
- The provider had a reducing restrictive practice policy to guide staff practice. Staff reported on restrictive practices at monthly governance groups. The hospital's

overarching action plan included plans for reducing restrictive practices. This included annual audits, identifying staff and patients leads, and attendance at regional meetings to share good practice from other sites.

- Following a risk assessment from staff, some patients had their own mobile phone. Some patients had a basic model phone with no camera or internet access which they could keep on the ward. Other patients had a smart phone, which they could keep in lockers at reception and could use only on section 17 leave. Some patients had pre-programmed numbers only which they could call.
- The hospital's action plan identified the planned introduction of the Safewards model from August 2018 onwards. Safewards is a nationally recognised initiative to improve patient involvement and help staff understand why wards can be unsafe at times.
- The provider included training in de-escalation and restraint techniques as part of management of actual or potential aggression training for staff. Staff reported that restraint was rarely used, and only after de-escalation techniques had failed. The provider had a prevention and management of violence and aggression policy in place to guide staff practice. This included guidance on de-escalation techniques. We saw that patients who had been subject to restraint had positive behavioural support and as required medicine plans in place. These directed staff in the use of least restrictive interventions before escalating to the use of restraint or rapid tranquilisation.
- Staff we spoke with demonstrated an awareness of the definition of restraint, as outlined in the Mental Capacity Act.

Safeguarding

- The provider made safeguarding training available to staff, and reported a completion rate of 94%. The training was delivered online and included the safeguarding of adults and children. Staff knew how to raise a safeguarding concern, and did so when appropriate. Safeguarding was included as an agenda item in staff supervisions.
- Between June 2017 and May 2018, staff had raised 29 safeguarding concerns with CQC. When we visited, the hospital manager was investigating a recent incident to determine if staff had acted appropriately to safeguard a patient at risk. Two further incidents resulting from omissions in care had resulted in a referral to safeguarding.
- Staff described how they would protect patients from harassment and discrimination. This included monitoring patient interactions for evidence of bullying. Staff received training in equality and diversity, and there was policy to guide staff practice.
- Staff knew how to identify adults and children at risk of, or suffering significant harm. Staff accessed the safeguarding lead and policy for guidance. The hospital's social worker led in escalating concerns, liaison with external agencies, and ensuring feedback from the local authority.
- The provider had safe procedures for children that visited the hospital. The hospital social workers assessed the suitability and risk of children visiting prior to visits taking place. All visits to the hospital involving children occurred in the visiting room.

Staff access to essential information

- Staff used a combination of electronic and paper records that acted as the patient's care and treatment record. Staff accessed patient care plans, daily risk assessments and continuing records electronically. However, staff printed and maintained a paper record of this information that was available in ward offices. Risk assessment, incident reports and additional assessments, also formed part of this paper record. Staff kept physical health folders for each patient in the clinic room. This included all physical health monitoring and a record of appointments with other physical health professionals.
- Staff stored paper records securely in locked offices and accessed electronic notes with individual passwords. The provider had recently granted two logon identifications and passwords to allow agency nurses access to electronic records when they worked at the hospital.

Medicines management

- The provider had established medicines management practices in relation to medicines reconciliation, ordering, delivery and checking medicines. Staff kept a record of drugs liable for misuse. However, the record did not demonstrate that two staff always recorded

when they had checked or administered these drugs. There was a contract in place for the disposal of clinical waste. Staff had access to current British National Formularies for reference.

- During the inspection, we reviewed nine medicine charts. We found all medicine charts were in good order, contained a complete record of medicine administration, and recorded patient allergies or drug sensitivities.
- The provider had a four-stage programme of medicine self-administration available to patients. The multidisciplinary team assessed a patient's suitability and safety to self-administer medicines prior to commencing the programme. Where required, medicine charts were accompanied by medicine self-administration paperwork that stated the patient's stage of in the programme and the necessary staff checks to ensure the patient remained safe to self-administer medicine.
- An identified pharmacist visited wards weekly to audit medicine administration charts and medicines management practices. Reviews included administration omissions, medicine self-administration practices, and storage of drugs liable for misuse. Following a visit, the pharmacist submitted a report of outstanding actions to the hospital manager, who then circulated it to ward staff. We reviewed two pharmacist reports, both demonstrated staff had completed all outstanding actions.
- The provider had systems in place to manage medicine administration errors. When an error was identified, it was reported as an incident and the qualified nurse responsible was required to complete a reflective account. Between, June 2017 and May 2018 staff reported 71 medicines related incidents.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance. This included blood tests, electrocardiograms and Liverpool University Neuroleptic Side Effect Rating Scales. At the time of our inspection, no patients required high dose antipsychotic monitoring.

Track record on safety

- Between June 2017 and June 2018, the hospital recorded six serious incidents. The most frequent type of serious incident had been disruptive, aggressive, or violent behaviour, and absence without authorised leaves.

Reporting incidents and learning from when things go wrong

- Staff knew what events to report as an incident. Staff used an incident reporting form to record incidents, recorded details of the incident in patients care records and, where necessary, updated risk assessments. Staff had access to a range of policies to guide their practice in the reporting and management of incidents.
- Staff reported all incidents that they should report. Between May 2017 and July 2018 staff reported 820 incidents. Ancaria ward accounted for 572 incidents, and Acorn ward 139 incidents. A further 109 incidents were reported from other areas of the hospital. Categories of incidents reported included episodes of violence and aggression, episodes of self-harm, accidents, medication errors, and security breaches.
- Staff were open and transparent and explained to patients when something went wrong. The hospital's policy for incident reporting and management detailed what Duty of Candour applies to, and the requirements and processes for staff to follow. Staff could give examples of speaking to patients and carers when things went wrong. This included an explanation of the incident and a written apology.
- Senior staff met to discuss all newly reported incidents at the daily morning meeting. Senior staff discussed all incidents and reported on all serious untoward incident investigations at monthly integrated governance meeting.
- Staff experience of receiving feedback from the investigation of incidents was poor. Senior and multidisciplinary staff met to discuss incidents and share feedback daily. However, staff were not clear on how this was shared with ward staff, particularly nursing assistants. Some staff felt that the recently introduced inclusion of a nursing assistant at the morning meeting was improving communication to ward staff. Learning from incidents was not a standing agenda item for staff meetings. The hospital manager reported that this was being introduced on the recommendation of the

Forensic inpatient/secure wards

provider's quality group. The hospital manager had commenced circulating lessons learned to multidisciplinary and nursing staff. However, nursing assistants had yet to be included in this.

- Senior staff could describe some changes that had been made because of feedback from the investigation of incidents. For example, changes to prevent the reoccurrence of absences without authorised leave.
- Staff experience of debrief following an incident varied. However, many staff we spoke with reported that debrief, often led by a senior staff member, was offered following a serious incident. Ward staff often identified that staffing levels or participation in ward duties prevented them from attending debrief when it was offered. The hospital offered confidential counselling to staff as part of its employee assistance programme. This was free to access and operated every day of the year.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed eight care and treatment records. All contained a comprehensive assessment that staff had completed during the initial patient assessment period. Areas of assessment included mental health history, medical history, offending history and substance misuse. Staff also completed a self-assessment document with patient. This included the patient's emotions, interests, and long-term goals.
- Seven of the eight records reviewed demonstrated that staff completed a full physical health examination on admission and provided ongoing monitoring of physical health needs.
- Care plans were present in all the care and treatment records reviewed. Care plans addressed the individual needs of patients, linked to assessments and covered a full range of needs. Additional care plans provided staff with guidance on the use of as required medicines and de-escalation techniques to manage aggression or agitation. We saw evidence of patient involvement, and plans demonstrated patients' strengths and goals
- Staff updated care plans when necessary, for example, when patients identified a new care need.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group, which included psychological therapies. Policy and procedure guidance to staff followed National Institute for Health and Care Excellence recommendations. Psychology staff offered a range of interventions appropriate to patients with a personality disorder presentation. This included dialectical behaviour therapy and trauma therapy. There were no waiting lists to access psychological therapies. Historically, the hospital provided a bespoke social model of psychological interventions. NHS England had expressed concerns about a lack of structured psychological therapies being offered to patients. This concern was included on the hospital's risk register and actions were present to address the concern.
- Staff ensured patients had good access to physical healthcare, including access to specialists when needed. Records showed that staff made a physical examination of patients on admission and provided ongoing physical health care. Patients told us they were happy with the physical healthcare they received and that staff arranged this promptly when needed.
- All patients were registered with a local general practitioner surgery and dentist. A doctor from the surgery visited the hospital to see patients once a fortnight. Patients able to attend for physical healthcare appointments in the community were encouraged to do so. The hospital was introducing onsite provision of optician and chiropody services.
- Following the staffing review, the hospital had created a vacancy for a physical health nurse to work eight hours a week.
- The hospital had initiatives in place to support patients to live healthier lives. This included access to a gym, regular walking, cycling and gardening groups, healthier options on menus and annual health checks.
- Staff used recognised rating scales to assess and record severity and outcomes. Staff used Health of the Nation Outcome Scales to record and review a patient's progress. Occupational therapists used the Model of

Human Occupation Screening Tool to gain an overview of patients' occupational abilities. Staff also provided examples of other tools including the Recovery Star, and personality disorder specific assessments.

- Staff had access to information technology that assisted them to support patients effectively. For example, the provider's intranet gave staff access to policies and procedures to guide their practice. Staff supported patients to access the hospital's information technology room.
- The hospital had an annual clinical audit programme that staff participated in. The hospital's overarching action plan identified additional audits to be completed, including complaints and incidents. The hospital benchmarked its performance against other local Cygnet Healthcare services. Staff met to discuss this at regional operational governance meetings.

Skilled staff to deliver care

- In addition to qualified nurses and nursing assistants, the hospital had a multidisciplinary team to meet the needs of patients. This included a consultant psychiatrist, a speciality doctor, an occupational therapist, a social worker, a psychologist, two assistant psychologists, and two therapy coordinators. When we visited, some members of the multidisciplinary team were new to post, including the psychologist and therapy co-ordinators. The hospital manager had been in post for three months.
- Additional visiting professionals contributed to the multidisciplinary team. This included a general practitioner, speech and language therapist, dietician, podiatrist, pharmacist, and music teacher.
- The hospital was supported by regular human resources reviews to ensure that staff were qualified and experienced for the positions they held. The reviews included professional registration and Disclosure and Barring checks. There was a recruitment, selection, and appointment policy and procedure to support managers through the recruitment process. The hospital stored staff records securely and only authorised staff had access to them.
- The hospital had been introducing a more comprehensive induction package for new staff in response to staff feedback and concerns about staff retention. This new package had been agreed with the provider's quality team. Induction practices included online mandatory training, the management of actual or potential aggression training, and the opportunity to work supernumerary on wards. Induction used the Care Certificate standards as a benchmark for nursing assistants and the hospital had two staff trained as Care Certificate assessors.
- All new staff were subject to a six-month probationary period. Supervising staff reviewed progress monthly and, after six months, formally assessed the staff members conduct against agreed performance criteria.
- The service provided staff with supervision. Supervision is a meeting to discuss case management, to reflect on and learn from practice, personal support and professional development. The hospital had increased the frequency of staff supervision to monthly, this followed a recommendation from NHS England. Between January and June 2018, the hospital had a supervision rate of 78%. This fell slightly below that target rate of 85%. Staff recorded, signed and shared copies of supervision discussions. Senior staff monitored supervision rates during integrated ward governance meetings.
- The hospital provided staff with annual appraisals of their work performance. Appraisals included discussion about continued professional and career development. At the time of our inspection, the hospital manager reported that 93% of non-medical staff that had an appraisal.
- Managers ensured that staff had access to regular team meetings. Records showed that meetings followed an agenda, were recorded and copies were available for staff to view. Items discussed during meetings included staff morale, and staff conduct. The hospital manager planned to add lessons learned as an agenda item, this followed a recommendation from the provider's quality team.
- Managers discussed learning needs with staff during supervision and appraisals. The hospital had an annual training plan that identified mandatory and additional training to equip new staff members essential to their roles.
- Managers made specialist training available to staff. The annual training plan included personality disorder specific training for staff. This included the reinforce appropriate, implode disruptive (RAID) training. However, staff believed there was not enough training

specific to personality disorder offered to them. Professionally registered staff had access to mentorship training that would allow them to supervise learners in the hospital.

- Managers initially addressed poor staff performance in probation reviews or supervision. The organisations human resources department supported managers to escalate and manage concerns. The human resources review identified staff subject to disciplinary or performance management concerns. Between January and June 2018, the hospital reported two incidents of staff suspension. Both incidents had been investigated and one had resulted in disciplinary action.
- When we inspected the hospital, it did not have any roles filled by volunteers.

Multi-disciplinary and inter-agency team work

- Senior and multidisciplinary team staff attended daily morning meetings at 9.30am. Staff discussed staffing levels, incidents, patient risk levels, patient observation levels, and patient community leave. We observed one morning meeting during which staff discussed the use of seclusion, incidents from the previous day and outstanding complaints.
- In addition to the daily morning meeting, staff held a weekly multidisciplinary team meeting. During the meeting, staff discussed and reviewed the care and treatment of six patients. This meant that patients had a formal review of their care and treatment once every four weeks. We did not observe a multidisciplinary team meeting during our inspection.
- Ward staff held handover meetings at changes of shift during the day. Staff recorded patient information in a handover book that was available in ward offices. We found omissions throughout the handover book on Ancaria ward. This included failing to record totals for patients on the ward or on leave, and staff signatures. The standard of recording information about individual patients also varied. Some entries recorded risk level, some recorded observation levels, and some recorded neither. Staff reported that handovers were not always informative, particularly if they had been off for a long period.
- Poor recording and communication of handover information had been indicated in two recent hospital incidents. Staff had not recorded information about the planned treatment, and instructions to manage the patient prior treatment in the ward handover book or ward diary. This had resulted in a patient missing two planned treatment interventions and was escalated to the local authority as a safeguarding concern.
- Staff described good working relationships with teams outside of the organisation. This included the general practitioner service, local colleges, and local voluntary services. Records showed that the hospital had not always correctly notified incidents to NHS England. This was included on the hospital's risk register and included actions to address the concern.

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

- The provider made Mental Health Act and Code of Practice training available to staff as part of mandatory training requirements. At the time of our inspection, only 45% of eligible staff had received training. The hospital manager demonstrated that compliance would be significantly improved following planned training days in September.
- Registered staff, including nurses, demonstrated understanding of the Mental Health Act, Code of Practice and guiding principles. Nursing assistants demonstrated some understanding, but felt the Mental Health Act and Code of Practice training offered was not sufficient for their roles.
- The hospital employed one whole time equivalent member of staff to provide administrative support on the implementation of the Mental Health Act and its Code of Practice. In addition, the hospital held a contract with an external organisation who could provide legal advice when needed. Staff knew who their Mental Health Act administrator was.
- Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Policies and procedures reflected the most recent guidance available. Staff accessed policies online and a copy of the Code of Practice was at the hospital.
- The hospital's information handbook for relatives, friends and carers included information on the Mental Health Act in accessible language.
- Patients had access to information about Independent Mental Health Act advocacy services and posters were displayed throughout the hospital. We saw an advocate visiting patients during the inspection.

Requires improvement

Forensic inpatient/secure wards

- Staff provided information to patients in line with section 132 of the Mental Health Act. Staff explained to patients' their rights under the Mental Health Act and made information leaflets available. Staff recorded in care records when this had been completed.
- Staff risk assessed patients prior to them taking Section 17 leave (permission for patients to leave hospital) when this had been granted. We saw examples of changes to Section 17 leave when patients had not adhered to the conditions of leave. Staff gave examples of occurrences when patients had not been able to take granted leave because of over activity booking or staff shortages.
- Staff adhered to consent to treatment and capacity requirements. We reviewed nine medicines charts and those needing legal authorisation had correctly completed forms attached. This meant that nurses administered medicines to patients under the right legal requirements. Staff requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored Mental Health Act paperwork securely. Original documents were kept in the Mental Health Act administrator's office and copies were on wards, filed in patients' care records.
- Staff reported that Section 117 aftercare meetings took place for patients who had been subject to Section 3 of the Mental Health Act or equivalent Part 3 powers authorising admission to hospital for treatment. These meetings identified aftercare services to be provided for relevant patients.
- Mental Health Act administrators monitored adherence to the Mental Health Act. This included regular audits.

Good practice in applying the Mental Capacity Act

- The hospital made Mental Capacity Act training available to staff as part of mandatory training requirements. At the time of our inspection, only 45% of eligible staff had received training. The hospital manager demonstrated that compliance would be significantly improved following planned training days in September.
- Registered staff, including nurses, displayed a good understanding of the Mental Capacity Act and particularly the five statutory principles. Staff with a poorer understanding identified the need to have training.
- Between January and June 2018, the hospital had made no Deprivation of Liberty Safeguard applications.
- The provider had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards. Staff were aware of the policy and knew how to access it.
- Staff knew where to get advice regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. This included accessing the policy and speaking to Mental Health Act administrators or senior clinical staff in the hospital.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. Records demonstrated that staff made and recorded capacity assessment for significant, specific decisions including the capacity to consent to treatment.
- Records showed that, for patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. This was done on a decision-specific basis regarding significant decisions. Staff met and discussed when a patient's capacity was in question.
- When patients lacked capacity, records showed how staff made decisions in a patient's best interests, recognising the importance of the person's wishes, feelings, culture and history. Records showed that staff organised case conferences involving all professionals, advocates, families and carers to inform decisions about patient care.
- Mental Health Act administrators monitored adherence to the Mental Capacity Act. This included regular audits. Staff included discussions about the Mental Capacity Act at integrated governance meetings.

Are forensic inpatient/secure wards caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

- Patients told us some staff were rude, disrespectful and bullying. Patients raised the issue of staff behaviour and feeling disrespected in ward community and Peoples Council meetings. In these meetings, staff encouraged patients to make complaints and speak to the advocate about their concerns. Records confirmed that staff did

not always speak and behave appropriately to patients. However, records also confirmed that managers took action to address poor staff performance when it was identified.

- Patients told us the staff who were caring were leaving their jobs. Patients told us high staff turnover and agency staff use created inconsistencies in care and made it difficult to build rapport with staff.
- Most staff and patient interactions we saw were patient-led with staff responding to patients rather than approaching them to initiate support. However, we saw a member of staff and a patient engaged in a 1:1 activity which was positive and respectful. Patients told us they did not trust staff and felt information staff recorded about them in observations was untrue.
- Patient and staff told us that staff did not always maintain confidentiality of information. Patients told us they knew about other patients' offending history from staff. Staff also raised concerns that their personal information had been shared with or overheard by other patients. We raised this concern with the hospital manager who reported that no formal complaints related to this concern had been raised. However, they did report that ward offices were not adequately sound proofed and we saw no signage displayed in offices reminding staff of this. During our inspection, we saw one example of staff leaving a patient confidential document record in clear view from outside of the office. Patients often gathered outside the office when seeking staff assistance, increasing this risk to the confidentiality of information.
- Patients and staff told us that they had concerns about people, other than staff employed by the hospital, visiting wards. We raised this with the hospital manager who reported that on occasions, in accordance with hospital policy, people other than hospital staff could be escorted to visit wards. This included interview candidates and family members. However, staff did not routinely consult with patients prior to this happening, or advise them when visits would occur.
- Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes from staff towards patients without fear of the consequences.

Involvement in care

Involvement of patients

- Staff did not always keep patients informed of changes to the service. Staff told us that communication amongst staff and between staff and patients was often poor. This led to inconsistencies in staff setting boundaries and created conflict between staff and patients. Patients told us the provider had introduced new policies without staff telling patients about them. Staff discussed this in clinical governance meetings and allocated a staff member to inform patients of new policies in ward community meetings.
- Staff involved patients in decisions about the service. This included staff recruitment, participation in the People's Council, and a patient representative from the People's Council attending monthly governance meetings.
- Patients could raise issues about their care and treatment. Staff told us patients could do this in monthly ward rounds and could request to see their doctor or named nurse in between ward rounds.
- Although staff involved patients in care planning, the administrative processes needed improving. We looked at eight patient care plans. They were person centred, holistic and recovery orientated. However, six of the eight patients had not signed their care plan. Staff recorded that one of these patients had declined to sign his care plan. Staff did not record if they gave patients a copy of their care plan in four of the eight records. The hospital's overarching action plan included improvements to care planning practices. For example; ensuring care plans are signed by patients and staff.

Involvement of families and carers

- Staff enabled families and carers to give feedback on the service and be involved in service development. Staff held six-monthly carers forum meetings. Staff and carers worked together to create a carers handbook. This handbook was available in reception. It included information about the hospital, visiting policies, staff, a sample patient menu and information about the Mental Health Act 1983. Staff provided guidelines for low secure services and implemented The Triangle of Care model in response to carers requesting this. The Triangle of Care model promotes collaborative working between patients, carers and staff. We saw that a guide to the model was available in reception and there was information about it in the carers handbook.

Requires improvement

Forensic inpatient/secure wards

- The hospital had information leaflets on the regional carers hub and advocacy service in reception. The hospital also conducted carer surveys and reviewed the responses in clinical governance meetings.
- In August 2018 the hospital hosted a barbeque for patients and families. Staff told us that this was an annual event. Carers gave us positive feedback about this event.
- Visitors could give feedback on the hospital via feedback forms in reception.
- Carers told us staff were polite, caring and respectful. Some carers told us staff invited them to their family member's care reviews and updated them on changes to their physical health and medication.

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

Good

Access and discharge

Bed Management

- The provider's website had clear information on bed availability and how to make a referral. NHS England's specialist commissioners funded the hospital's beds. The provider had a central online referral team who processed referrals.
- Between January and June 2018, the average bed occupancy at the hospital was 83%. This meant beds were available when NHS England made referrals.
- Staff told us that for patients' subject to Ministry of Justice conditions it took on average four to eight weeks from initial assessment to admission. Ministry of Justice conditions apply to patients detained under the Mental Health Act 1983 and treated in a hospital instead of being in prison.
- Staff assessed patients promptly and supported them, in line with the hospital admissions policy. The doctor and a member of the multidisciplinary team completed patients' admission assessments within 48 hours of receiving referrals. Staff assessed patients in their existing placement so the environment was familiar to them. Patients could have a pre-admission orientation visit to the hospital. Staff deep cleaned and redecorated bedrooms and provided a new mattress for each new patient. Once admitted, staff gave new patients a welcome pack, additional support and basic toiletries.
- Between June 2017 and June 2018, the average length of stay for a patient on Ancaria ward was 10 months. In the same period, the average length of stay for a patient on Acorn ward was 29 months.
- Between January and June 2018 there were two out-of-area placements to the hospital. Out-of-area means patients whose home address was more than 50 miles away.

Discharge and transfers of care

- There was a pathway of progression, allowing patients to move from Ancaria to Acorn ward as their mental health improved. The hospital admitted most patients to Ancaria ward for assessment. When the multidisciplinary team agreed they were ready to progress, patients then moved to Acorn ward for rehabilitation and discharge preparation. Sometimes staff moved patients between wards if there were issues with relationship dynamics or safeguarding.
- Staff told us they planned discharges from admission and reviewed them in multidisciplinary and Care Programme Approach meetings. However, of the eight patient care records we looked at only one had a discharge care plan.
- Between January and June 2018, there were no delayed discharges reported from the hospital. However, in one case another hospital assessed and accepted a patient, but the hospital then closed, preventing the move. Staff continued looking for an alternative placement for this patient.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients' bedrooms supported their comfort, privacy and dignity. Patients had their own bedrooms and did not have to sleep in bed bays or dormitories. Bedrooms had an ensuite shower and toilet. Bedroom doors had viewing panels which opened and closed. This meant staff could observe patients in their bedrooms while also allowing privacy. Patients had access to their bedrooms during the day.
- Patients could personalise their bedrooms and bring in belongings and items of furniture. This promoted comfort and person-centred care. The hospital

implemented the new providers' policy on patients bringing in personal items. It differed from the previous providers' policy. The new policy introduced stricter risk assessments and restrictions on the amount and type of belongings patients could bring in. Staff and patient representatives discussed this at Peoples Council and ward community meetings.

- The ward communal areas were adequate. Patients chose the décor of the lounge and had ordered soft furnishings. Patients planned to redecorate the dining room and discussed this in Peoples Council meetings. The furniture in communal areas was well maintained. Patients and carers gave feedback that the visitors' room was not a nice environment. Staff discussed ways of improving the visitors room in clinical governance meetings.
- Staff and patients had access to a range of rooms and equipment to support treatment and care. Both wards had clinic, activity and therapy rooms, a lounge, quiet room and dining room. There were woodwork, computer and art rooms. We saw patients taking part in a computer group and saw that patients were supported to cook their own breakfast on the wards. Both wards had pool tables that patients could use under staff supervision. The hospital had a gym which staff were trained to facilitate sessions in. However, patients reported in community meetings that there were delays in receiving gym induction.
- The hospital had a secure garden that patients could access under staff supervision. However, patients told us there were delays in accessing fresh air due to staffing.
- Staff told us there were issues with scheduling too many patient activities such as section 17 leave and appointments to happen at the same time. This made it difficult for staff to support the activities for all patients. In response to this staff recorded patient activities in the ward diary. They referred to this in morning staff meetings to ensure staff were aware of patient schedules. Staff also wrote patients' activities for the day on their allocation sheets.
- Staff and patients told us that there had not been regular activities taking place on the wards due to staffing. However, this had improved since the hospital appointed two activity coordinators. Their shifts covered a seven-day rota.
- The hospital had facilities for a recovery college and planned to increase the activities available to patients. Staff and patients discussed ways of developing the recovery college in ward community and People's Council meetings. Staff planned to visit, and learn from, another hospital that had an established recovery college.
- The hospital had a visitors' policy and staff informed visitors about security procedures. Only people approved by the social worker could visit patients. Sometimes the social worker did home assessments prior to approving visitors. Carers' feedback showed they found home assessments useful. Nursing staff booked in visits for approved people. There were two visitors' rooms near reception where patients could meet visitors in private.
- Patients had somewhere secure to store possessions. They could use ward safes and lockers in reception. Patients told us they could keep a small amount of money in their possession but that staff discouraged this for safeguarding and security reasons.
- Patients without a mobile phone could make calls in private on the ward phone.
- Patients told us they were happy with the choice and quality of food. Patients on both wards had could make hot drinks 24 hours a day. Staff on Ancaria ward could make snacks for patients 24 hours a day. Patients on Acorn ward could make their own snacks 24 hours a day.
- Patients told us they did not have access to a hairdresser at the hospital. This meant patients who did not have section 17 leave were not able to get their hair cut. Patients told us this meant they either had to shave their heads or let their hair grow, which was not their preference. A carer also told us that access to a hairdresser was a problem.
- Patients told us the hospital did not have a shop which made purchasing items difficult. There were issues with patients ordering items without staff approval. The hospital's policy on patient purchases was that patients requested items and staff discussed whether to approve them in morning staff meetings. Nurses could approve some purchases without this discussion. Patients were writing a list of more shopping items they wanted nurses to be able to approve without discussion. Staff and patients discussed the development of the list in ward community meetings and Peoples Council meetings.

Patients' engagement with the wider community

- Staff ensured patients had access to spiritual support. Some patients identified as Christian, no patients

identified as any other religion. The hospital had links with a Christian organisation that attended as part of the hospital recovery college. Some patients attended local church services to meet their spiritual needs. The hospital had resources to support multi-faith worship, but did not have a dedicated multi-faith room. However, during the inspection the hospital manager took immediate access to resolve this.

- Subject to risk assessment, staff ensured that patients had access to education and work opportunities. Some patients did college courses of their choice. One patient did community-based voluntary work. Some patients attended community groups for people with protected characteristics. Protected characteristics are attributes covered under the Equality Act. For example, disability, gender reassignment, sexual orientation, ethnicity and religion. The hospital had a minibus and staff registered as drivers to take patients out on leave or to community based activities.

Meeting the needs of all people who use the service

- Wards had a range of information available to patients. The subjects included advocacy, how to make Mental Health Act complaints, solicitors for tribunal cases, safeguarding, contraband items and patient activities. All information was in English but staff told us how they could get information translated into other languages. At the time of our inspection there were no patients who did not have English as a first language. Staff told us that for a patient who had a low reading level, they offered to read his mail to him.
- The hospital catered for patients with dietary intolerances. At the time of our inspection there were no patients with specific religious, cultural or special texture dietary requirements.
- The hospital was accessible to all who needed it and took account of patients' individual needs. Staff made adaptations for patients with restricted mobility for example, by allowed them to use the lift, store their mobility scooter in the hospital grounds and providing a shower chair. All ensuite facilities had step-free wet room showers.

Listening to and learning from concerns and complaints

- Staff and patients told us they knew how to make a complaint, but were not confident the hospital would make changes if they did. The provider displayed information on how to make a complaint, and there were complaint forms on the wards which patients could complete and send to the hospital manager. Carers also told us they knew how to make a complaint.
- Between January and June 2018, the hospital received 33 complaints. They upheld 19 of these. Themes included poor communication, a lack of patient activities and patient belongings going missing. There were no complaints referred to the Ombudsman.
- Managers told us they logged and acknowledged complaints within 48 hours, investigated them and gave written feedback. We looked at two complaints received in July 2018 and August 2018. We found evidence that staff followed policy guidance and kept records of complaints received. This included letters of acknowledgement to complainants, the investigation process and outcome letters to complainants.
- The hospital manager planned an audit of complaints to address a concern that an excessive number of complaints had been issued with an acknowledgement letter but no follow up. The service attributed this to a lack of complaints gatekeeping by staff and was identified on the hospital's risk register.
- Although the provider listened to and investigated concerns and complaints, it did not always learn lessons from the results. There were no established practices to share lessons learned from complaint investigations amongst staff.
- Patients could give feedback on the service directly to the provider and independently through a patient advocate. The hospital had a Peoples Council and fortnightly ward community meetings in which patients could raise complaints and concerns. A patient representative from each ward also attended monthly hospital governance meetings. Patients could raise concerns with the advocate who visited twice weekly. The advocate fed these concerns back to the hospital governance meeting. Staff reviewed action points from patient community meetings in clinical governance meetings to check actions had been complete. However, patients reported they did not receive feedback from these meetings.
- Between June 2017 and June 2018, the hospital received two compliments.

Are forensic inpatient/secure wards well-led?

Requires improvement

Forensic inpatient/secure wards

Requires improvement

Leadership

- The hospital manager had been in post since June 2018 and was in the process of registering with CQC. The previous hospital manager had only been in post between August 2017 and March 2018, and had not registered with CQC. In addition to the hospital manager, a senior member of Cygnet Healthcare staff had been working at the hospital for nine months to provide management support.
- The hospital manager was new to low secure services. They had been the CQC registered manager of another hospital site, where they had demonstrated the skills, knowledge and experience to perform their role. The hospital manager reported feeling supported in their new role by the hospital's multidisciplinary team, senior staff, and by the provider's senior management team and governance structures. The hospital manager described plans to support ward staff to provide high quality care. This included establishing greater leadership at ward level, staff training, and staff supervision.
- We saw that the hospital manager and senior staff were visible in the service and approachable for patients and staff. The regional operations manager visited the hospital regularly and was also available to patients and staff. Staff experience of senior hospital staff was good, describing them as approachable and understanding. Staff had reservations about the new hospital manager, reporting that on occasions they had not been visible or supportive of staff.
- The provider made leadership development opportunities available to staff. This included visionary leaders training for hospital managers and leadership apprentices for senior ward staff.

Vision and strategy

- Senior staff knew and understood the provider's vision and values and how they were applied in their work. All staff had access to an intranet that included videos of staff speaking about the organisations core values and what this meant to them.
- The provider's values were displayed to staff when they accessed the intranet. Similar information was available to patients, family members, carers and other professionals on Cygnet Healthcare's main website. The hospital manager reported the organisation's values were reflected in the structures of staff recruitment and supervision.
- The provider reported their values had been developed by staff through involvement in workshops and staff surveys. Staff at the hospital did not report they had contributed to this process.
- The hospital manager could explain how the provider was working to deliver high quality care within the budgets available. Cygnet Healthcare had become the registered provider of CQC regulated activities in April 2018 and there was evidence of investment into the hospital since then. This included increasing staffing establishments, the introduction of electronic door locks, improvements to the alarm system, and other proposed environmental improvements.

Culture

- Staff we spoke with reported poor communication, low morale, and an unhappy staff team at the hospital. Common concerns included a high staff turnover rate, inexperienced new staff, inconsistent application of staff and patient boundaries, and poor induction and training opportunities,
- Staff did not report feeling positive and proud to work at the hospital. Only one member of staff reported to us they enjoyed working at the hospital. Another staff member believed recent changes were having a positive impact on culture and morale at the hospital. Staff survey results showed only 10% of staff would definitely tell people the hospital was a good place to work.
- The hospital had a whistleblowing process in place. The hospital had also organised drop-in human resources sessions that allowed staff to raise concerns confidentially.
- Managers dealt with poor performance when needed. Between January and June 2018 there had been two staff suspensions. One of these had resulted in disciplinary action. Staff meeting records showed that managers raised concerns with staff directly. This included addressing low staff morale and incidents of staff swearing at patients.
- Staff did not report that teams worked well together. This included a feeling of separation between

multidisciplinary staff and ward staff, and poor communication throughout the hospital. Some staff believed the new management structure was listening to staff concerns and was keen to address issues.
- Staff appraisals included conversations about career development and how it could be supported.
- Staff completed equality, diversity and disability training as part of mandatory training requirements. When we inspected, 94% of staff had completed this training. Staff made an equality and diversity assessment on all policies and procedures introduced at the hospital. Equality and diversity impact assessments help organisations to make sure they do not discriminate or disadvantage people.
- The staff sickness rate in the last 12 months was 5.5%. This was higher than the NHS average of 4.8%. Of greater concern was the hospital's high staff turnover rate in the past year and the consequences of that.
- The provider had a health management programme that provided staff with support for their own physical and emotional health needs. This included a counselling helpline and vaccinations.
- The provider had an awards programme that recognised the success of teams and individual staff members.

Governance

- The service did not have clear frameworks of what must be discussed at ward level. For example; lessons learned had not routinely been included as part of staff meeting agendas. Where frameworks did exist, we saw that staff did not always use them effectively. For example; omissions and poor recording in ward handover records. Also, there had not been a clear process to enable information sharing between senior staff attending the daily morning meeting and ward staff. However, staff felt this was improving following recent changes.
- The provider had a clear framework of what must be discussed at integrated governance and regional operational governance meetings. This included key performance indicators to gauge the performance of services, and benchmarking performance against similar services within the region.
- We saw evidence of the new provider acting to implement recommendations from reviews of incidents, concerns, and external organisations. This included responding to recommendations from NHS England, the provider's quality team and staff feedback. The provider had developed an overarching action plan to address concerns identified across 13 areas. Many of the concerns identified by the inspection team were already known to the provider and included on the service's risk register and action plan. When we inspected not all actions had reached their completion date and completed actions were not embedded to demonstrate significant improvement.
- Staff participated in local clinical audits. However, audits had not been sufficient to provide assurance, and had not demonstrated how staff acted to address resulting concerns. The new provider had introduced a new monthly and annual clinical audit programme, and additional audits to address existing concerns. These were clearly identified on the service's overarching action plan.
- Staff did not always understand the arrangements for working with other teams to meet the needs of patients. This included failing communicate effectively within the hospital and failing to make notifications to external bodies as needed. However, staff did know how and when to refer to teams outside of the service including safeguarding, voluntary, and community services.

Management of risk, issues and performance

- The hospital had a local risk register in place. The hospital manager reported that staff could submit items to the risk register through the People's Council or escalate concerns directly with them. Staff were introducing discussions about the risk register as a standing agenda item in integrated governance meetings. The hospital manager had commenced circulating the risk register to multidisciplinary and nursing staff.
- The hospital's risk register reflected staff concerns in relation to induction processes, the experience of new staff, and boundaries between staff and patients. Actions were present to address concerns.
- The hospital had a business continuity plan to prepare for, and manage emergencies. For example; adverse weather or infection outbreaks.
- The hospital manager reported that there were no financial restrictions or cost improvements taking place. We saw evidence of investment from the provider that would improve patient care at the hospital.

Information management

Requires improvement

Forensic inpatient/secure wards

- Hospital administration staff contributed to the collection of data from wards. The hospital manager reported plans to introduce electronic data collection methods. For example, incident reporting data.
- Staff had access to the equipment and information technology needed to do their work. The hospital manager reported plans to make the electronic record the primary tool for recording information.
- Information governance systems included confidentiality of patient records. Staff completed information governance training as part of mandatory training requirements. When we inspected, 95% of staff had completed this training. Staff accessed electronic records privately and with the use of passwords. However, patients and staff raised concerns about the confidentiality of personal information, and we saw an example of staff not storing physical documents securely.
- The hospital manager had access to information to support them with their management role. The hospital used key performance indicators to gauge the performance. These included incidents, safeguarding, staffing, complaints, training and meaningful activity hours for patients. The provider presented key performance indicators in an accessible monthly report, they tracked performance against other Cygnet hospitals, and senior staff met to discuss them. Reports included actions to address areas of improvement.

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the service. This included intranet access for staff, a well-resourced reception area, and the provider's website.
- Patients had opportunities to give feedback on the service they received through ward community meetings and via patient representatives who attended People's Council and clinical governance meetings. They could also give feedback on their care in monthly ward rounds. However, patients reported they did not feel involved in decision making about changes to the service. Carers had the opportunity to give feedback in monthly carers forum meetings.
- Patients could meet with senior hospital staff at monthly governance meetings. A patient attended as a representative for patient and staff members of the Peoples Council.
- Senior staff reported they engaged with external stakeholders, including NHS England. However, a commissioning manager reported minimal communication from the new hospital manager and was concerned by this.

Learning, continuous improvement and innovation

- The hospital reported a commitment to innovation and quality improvement. They believed this was demonstrated through staff development, improvement and training, and patient and carer involvement. During the inspection we saw evidence to support both.
- The hospital had a research policy in place to guide staff practice. Multidisciplinary staff discussed research initiatives as part of monthly continuing professional development.
- The hospital did not identify participation in national audits relevant to the service.
- The hospital was part of the Quality Network for Forensic Mental Health Services. This is a quality improvement network for low and medium secure inpatient forensic mental health services across England. As part of this, in May 2018 the hospital had participated in a peer review. Peer review is a process of professional assessment by people working in the same field. At the time of our inspection, the results of this review had not been published.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff make regular checks of emergency equipment.
- The provider must ensure staff observation practices are undertaken in line policy guidance, good practice and keep risks to patients as low as possible.
- The provider must ensure staff monitor and record patient observations following the administration of rapid tranquilisation.
- The provider must ensure staff keep an accurate and complete record of the care and treatment provided to patients.
- The provider must ensure the handover of verbal and written information between staff is effective and minimises the risk of untoward incidents occurring to patients.
- The provider must ensure all eligible staff receive training in the Mental Health Act, and Mental Capacity Act that is sufficient to their roles.
- The provider must ensure staff treat patients with dignity and respect at all times.
- The provider must ensure staff maintain the confidentiality of information of all people using, or employed by the service.

Action the provider SHOULD take to improve

- The provider should ensure clinic cleaning records prompt staff to complete and record cleaning of portable examination equipment.
- The provider should ensure systems continue to be developed to increase all staff's awareness and understanding of lessons learned as result of the investigation of incidents and complaints.
- The provider should ensure that patients are consulted and informed when visitors are expected on wards.
- The service should ensure that all incidents are correctly informed to the relevant external organisations.
- The provider should ensure that patients are adequately informed and supported when new policies and procedures are introduced to the hospital.
- The provider should ensure staff offer patients copies of care plans and document when this has been done.
- The provider should ensure staff effectively plan shifts to prevent delays for patients accessing activities, fresh air or requiring staff support when returning from leave.
- The provider should ensure that care plans demonstrate active discharge planning for patients, including participation in recovery activities.
- The provider should ensure that patients have access to a dedicated space appropriate for multi-faith worship.
- The provider should ensure that practices are established to share lessons learned from the investigation of complaints amongst staff
- The provider should ensure that planned changes to the services improve staff experience, and this is demonstrated in staff feedback.

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 10 HSCA (RA) Regulations 2014 Dignity and respect • **Staff did not always treat patients with dignity and respect. Records and reports from patients confirmed this.** **This was a breach of regulation 10 (1)**

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 • **Staff did not always make regular checks of emergency equipment.** • Staff observation practices did not ensure that risks to patients were as low as possible and in line with good practice. • Staff did not always monitor and record patient observations following the administration of rapid tranquilisation. • **Communication between staff at handovers was poor, and had resulted in untoward incidents involving patients.** **This was a breach of regulation 12 (2) (b), (e)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

- Staff record keeping was not always accurate and complete.
- Staff did not always maintain the confidentiality of information.

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

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 18 HSCA (RA) Regulations 2014 Staffing • Staff training rates were low in relation to the Mental Health Act and Mental Capacity Act. This was a breach of regulation 18 (2) (a)