

# John Munroe Hospital

## Quality Report

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

### Ratings

#### Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

#### 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

Our rating of this location for people requiring long term rehabilitation and care for their dementia improved. We rated it as good because:

- The hospital provided safe care. The ward environments were safe and clean and fit for purpose. For example Rudyard ward had been adapted to meet the specific needs of patients with dementia . The wards had enough nurses and doctors to provide care and treatment for patients with dementia and for patients requiring long term rehabilitation. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff provided a range of treatments suitable to the needs of the patients on both the long-term rehabilitation and on Rudyard, the dementia ward. The hospital followed national guidance on best practice for all patients. Staff working on the long-term rehabilitation ensured that the orientation and quality of therapies helped patients in their recovery and rehabilitation. The focus for patients with dementia was to support the development of skills in decision making and help patients plan wherever possible. Staff working on Rudyard had received specialist training in the management of patients with dementia and all patients had access to independent advocacy services. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The hospital worked to a recognised model of mental health rehabilitation and dementia care. It was well led and the governance processes ensured that ward procedures ran smoothly. The registered manager, in post since the summer of 2018, had been instrumental in making significant improvements at the hospital. All staff recognised that these improvements, made with the full support of the hospital board, were essential to sustain and build upon.

However:

- The inspection team reviewed twelve care records across the long-term rehabilitation and dementia wards. Seven of these records showed that staff had not included personalised details and treatment goals for patients. These plans were therefore not holistic or recovery orientated. Clinical support workers, who provided most of daily the care for patients, did not have access to the daily electronic patient record and could not personally write their records directly on the system. This meant that detailed information from staff who had frequent contact with patients was not fully available for developing individual rehabilitation plans for patients. However verbal reports, given at handover, from clinical support workers were uploaded onto the electronic record by registered nurses.
- We found that hospital wards lacked a comprehensive range of accessible information on mental health problems, treatments, physical health problems and smoking cessation. All wards advertised independent advocacy services and all wards, except Kipling, had information on how to make a complaint.

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working-age adults	Good 	
Wards for older people with mental health problems	Good 	

# Summary of findings

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**Good** 

John Munroe Hospital

**Services we looked at**

Long stay / rehabilitation wards for working age adults

Wards for older people with mental health problems

# Summary of this inspection

## Background to John Munroe Hospital

John Munroe Hospital is an independent mental health hospital that provides care, treatment and rehabilitation services for up to 57 adults, aged 18 or over, with long-term mental health needs. Patients may be informal or detained under the Mental Health Act 1983. John Munroe Hospital is one of two hospitals run by the John Munroe Group Limited.

The Edith Shaw Hospital is located nearby and both hospitals share the same registered manager.

The chief executive of the John Munroe Group is the controlled drugs accountable officer and responsible for all aspects of controlled drugs management within the organisation.

John Munroe Hospital is registered to carry out the following regulated activities:

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

John Munroe Hospital has five wards. Three wards (Horton, Kipling and Rudyard) are located in the main hospital building. Larches and High Ash wards are located in self-contained bungalows.

- Horton ward is a ward for men that has 16 beds for patients with chronic or complex mental health needs.
- Kipling ward is a female-only ward for up to 13 patients with chronic or complex mental health needs
- High Ash is a female-only ward for up to seven patients and provides Highly Specialist Inpatient Rehabilitation

- Larches is a male-only ward for up to six patients and provides Highly Specialist Inpatient Rehabilitation
- Rudyard ward is an older adult male ward that supports up to 14 patients with organic mental health conditions such as dementia.

The last comprehensive inspection of John Munroe Hospital in February 2018 when it received an overall rating of requires improvement.

The CQC conducted a further inspection in June 2018. This inspection was a focused, unannounced inspection in response to medicines safety concerns raised to us by a whistle-blower.

During the inspection we found significant concerns around the management of medicines across all wards leading us to serve a Warning Notice, under Section 29 of The Health and Social Care Act 2008, and notified the hospital that it must comply with Regulation 12 of the Health and Social Care Act 2008 and ensure its nurses investigated medicines errors and receive training in medicines competency. In addition we told the hospital that it must incident reports for medicines errors and develop a reliable mechanism to monitor and manage the supply of medicines.

In December 2018 CQC conducted an unannounced inspection to check whether the required improvements identified in the warning notice had been made.

At this inspection we found that the provider had made the required improvements and so we lifted the warning notice.

## Our inspection team

The team that inspected the hospital comprised five CQC inspectors and two specialist nurse advisors.

## Why we carried out this inspection

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

# Summary of this inspection

## How we carried out this inspection

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

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

During the inspection visit, we reviewed information that we held about the location and received feedback from patients when we interviewed them on the wards at John Munroe Hospital.

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;

- spoke with six patients who were using the service;
- Spoke with the Registered Manager and the Clinical Nurse Managers for each of the wards;
- spoke with 16 other staff members; including doctors, nurses, occupational therapist, psychologist and the training manager;
- attended and observed one morning hand-over meeting
- conducted the Short Observational Framework for Inspection on one ward.
- looked at 12 care and treatment records of patients:
- carried out a specific check of the medicines management on all wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the service say

We spoke with six patients who were positive about the service. They told us that they found staff were kind and friendly, asked them what they needed and listened carefully to them. Patients we spoke to said they were involved in their care and overall thought there was enough activity taking place. All patients said that they felt safe in the care of the hospital.

In addition to direct feedback from patients, the inspection team used its short observational framework to capture the experiences of other patients at the

hospital. These were patients who had greater difficulties in communicating their experience of their care. The framework's observational process helped inspectors assess the mood and engagement of patients at John Munroe Hospital and the quality of staff interactions. Patients appeared content and demonstrated no signs of frustration or distress. Staff interactions with patients were recorded as good or neutral and patients enjoyed a friendly familiarity with the staff.

# 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?

Our rating of this hospital improved. We rated it as good because:

- The hospital's long-term rehabilitation wards were safe, clean, well equipped and fit for supporting patients in their recovery journey and included facilities for patients to develop and maintain independence in making food and drinks. Ruyard ward had a long-term estates plan to ensure it met the standards for a dementia-friendly physical environment and made continual assessments of its policies and procedures to make sure that its operations were sensitive to the needs of patients with dementia. The hospital had enough nursing and medical staff, who knew the patients and who received comprehensive induction and training to keep patients safe from avoidable harm. Staff were also supported with continuous professional development and received further training in person centred risk assessment, care planning, positive behaviour support de-escalation and harm reduction.
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The hospital used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.
- The wards had a good track record on safety. The hospital managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers

Good



# Summary of this inspection

investigated incidents and shared lessons learned with the whole team and the wider services of the hospital. When things went wrong, staff apologised and gave patients honest information and suitable support.

However;

- Clinical support workers did not have access to the electronic patient daily record and could not write care records directly on to the system to support registered staff in their clinical decision making.

## Are services effective?

Our rating of this hospital stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed care plans for each patient, which they reviewed regularly through multidisciplinary discussion and updated as needed but these were not always person centred.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and they supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.

Good



# Summary of this inspection

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Care plans did not always reflect the assessed needs of patients and were sometimes not personalised, holistic or recovery-oriented.

## Are services caring?

Our rating of this hospital stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately of changes in a patients presentation in accordance with the hospital's confidentiality policy.
- Feedback from patients was that they felt cared for by staff and enjoyed the food and activities

Good



## Are services responsive?

Our rating of this hospital stayed the same. We rated it as good because:

- The hospital liaised with patients and carers before admission to ensure there were no no long delays. Patients and carers could also visit the hospital beforehand admission to familiarise themselves with the hospital.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Good



# Summary of this inspection

- The design, layout, and furnishings of the wards within the hospital supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the hospital – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The hospital treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider hospital service.

However:

- There were mixed levels of accessible information on all wards, and on Kipling ward there was no information on how to complain. Other wards lacked comprehensive information on other sources of help and support for patients.
- Larches ward only had one patient toilet which included a shower meaning if the shower was in use there was no patient toilet available for use. A female patient's bedroom situated adjacent to Rudyard Ward had restricted access to the toilet and other facilities. This compromised the patient's privacy and dignity.

## Are services well-led?

Our rating of this hospital improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the hospital and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Good



# Summary of this inspection

- Staff engaged actively in local and national quality improvement activities

# 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.**

All staff had had completed mandatory training in the Mental Health Act and staff we spoke with had a good understanding of the Code of Practice and its guiding principles. After each teaching session on the Mental Health Act each member of staff was given a multiple choice competency questionnaire to test their knowledge. Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. There was a clear process for monitoring and checking Mental Health Act paperwork. Staff knew who their Mental Health Act administrator was and commented that they were always available to support them. Staff also had access to a reference folder with up to date Mental Health Act policies. Patients had their rights given to them every month. This was timetabled for each patient and the

inspection team saw this documented in care records. Staff stored copies of patients' detention papers and section 17 leave forms correctly so that they were available to all staff that needed access to them.

Patients had access to information about independent mental health advocacy and this was displayed on most wards we visited. Staff also ensured, where legally appropriate, that patients were able to take Section 17 leave from hospital. The Mental Health Act administrator carried out checks on this and other regular audits of Mental Health Act paperwork to demonstrate the providers compliance with the MHA and MHA code of practice. The hospital also displayed a notice to tell informal patients that they could leave the ward freely.

Recent examples of clinical audits carried out by the provider in the 12 months preceding the inspection that demonstrated compliance with the Mental Capacity Act included audits of Section 58, Treatment, Section 132, Rights, Section 17, Leave authorisation forms and leave risk assessment and a Deprivation of Liberty Safeguards documentation and application review.

## Mental Capacity Act and Deprivation of Liberty Safeguards

All clinical staff had received mandatory training in the Mental Capacity Act and staff we interviewed demonstrated an understanding of its statutory principles. This meant that staff knew when patients lacked capacity and made decisions in their best interests. They did this whilst recognising the importance of the person's feelings, culture and history. Staff also took all practical steps to enable patients with impaired mental capacity to make their own decisions and we saw evidence of this in the care notes.

The provider had an up to date policy on Mental Capacity Act and Deprivation of Liberty Safeguards and staff told us that they knew where to get advice regarding the Act. At the time of inspection there was one patient with a Deprivation of Liberty Safeguards application in process. The organisations Mental Health Act administrator monitored the progress of all Deprivation of Liberty Safeguards applications.

## Overview of ratings

Our ratings for this location are:

# Detailed findings from this inspection

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

## Notes

# Long stay or rehabilitation mental health wards for working age adults

Good 

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

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

Good 

### Safe and clean environment

Staff completed regular risk assessments of the care environment. This included the assessment of ligature risk on all wards. A ligature risk point is anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. John Munroe hospital last assessed these points on each of their wards between the months of May to September 2019. Any patient representing a high risk was placed in a bedroom with specialist furniture that prevented a ligature point from staying secure. In all other cases patients were risk assessed and enhanced observations were put in place if individual patients required these. Staff were trained in managing ligature risks and frequently updated patients risk assessments to reflect changing risk. These risks were then discussed in clinical meetings, including the Multi-Disciplinary Team meetings. Staff offices were always locked when unattended and communal areas were always staffed to monitor patients within the ward environment. On some wards there were blind spots that restricted staff observation. This was mitigated against by increased patient observations. The registered manager was also in the process of installing strategically placed mirrors so that staff had greater visibility of common areas.

All bedrooms on wards had a nurse call system. Staff were always available to respond to these alarms if necessary. All staff wore a personal alarm and used radios to further improve communications and to specify the type of assistance they required.

Clinic rooms on Horton, Rudyard and Kipling wards were well-equipped with the necessary equipment to carry out physical examinations. On High Ash and Larches wards the nursing offices doubled as clinic rooms. However this did not present problems in storing patients' medicines and emergency equipment.

All areas of John Munroe Hospital were visibly clean. All furnishings were fit for purpose and regularly maintained. The provider had an estates improvement plan and an established schedule of repair, maintenance and replacement for each ward.

Ward cleaning records were up to date and demonstrated that the premises were cleaned regularly. Records also showed that emergency resuscitation, blood pressure monitors and weighing scales and other medical equipment were cleaned and checked regularly.

There were adequate handwashing facilities, with handwashing instructions displayed above the sinks and staff we interviewed told us that they followed infection control practices.

### Safe staffing

The substantive clinical staff team at John Munroe Hospital comprised of 18.65 registered nurses and 94 clinical support workers. Three psychiatrists worked for two, three and four days each week. Two psychologists worked for three and four days each week and were supported by two whole time equivalent assistant psychologists. There were

# Long stay or rehabilitation mental health wards for working age adults

Good 

three whole time equivalent occupational therapists supported by an occupational therapy assistant and a technician who were also both full time staff. A local GP attended weekly to review patients presenting with physical health needs. Further support was also provided by a nurse practitioner, from a local GP surgery, who attended weekly to review any patients' needs. There were no vacancies for any of these clinical posts at the time of our inspection.

Wards had between one and two registered nurses on days and weekend shifts, with Rudyard and Horton requiring the most registered nursing staff. All wards had one registered nurse on shift at night. Additional clinical support workers were deployed on all wards at a ratio of one staff to two patients on days, and one staff to three patients on nights. These ratios could be adjusted in accordance with patient need. When bank and agency staff were required the provider prioritised use of its own bank and nursing agency staff. Other external nursing agencies were used as required.

In the year from 1 October 2018 to 1 October 2019 the provider used bank staff on 1364 day shifts and on 524 night shifts. Agency staff were used on 2847 days and 869 nights. All bank staff and the provider's agency staff received the same training as the provider's substantive staff. Following concerns raised about the conduct of a small minority of agency staff, the provider instigated quality assurance meetings with external nursing agencies to ensure all agency staff complied with Nursing and Midwifery Council standards. We were also told by the registered manager that he conducted quality audits of external agency staff every six months. The provider decided on its staffing levels by assessing the acuity of each of the wards. To do this they used an established and evidence based formula to make professional judgements on reducing risk and on the correct deployment of staff.

The staff sickness rate for the period from 1 October 2018 to 1 October 2019 was 4%. The staff turnover rate was between 0.6% and 6% across all wards, with the main reasons for leaving being to take up new employment and for personal issues.

The hospital had rapid access to a medical cover during the daytime and out of hours when required through a hospital doctor rota system.

Over 95% of all staff had received appropriate mandatory training. The provider's mandatory training program included safeguarding, first aid and life support training up to Immediate Life Support level.

## Assessing and managing risk to patients and staff

The inspection team examined 12 care records and found that staff completed a risk assessment of every patient on admission and updated it regularly, including after significant incidents. The provider assessed patients using a recognised risk assessment tool. This tool helped in identifying incidents or changes to risk. All risk assessments were completed comprehensively and contained detailed information on the risks themselves and demonstrated close monitoring of patients' mental health. The risk management plans were individualised and also included plans to reduce risks associated with specific risk issues, such as falls or pressure ulcers, physical health, self-neglect and vulnerability to exploitation by others.

Care and treatment on the ward demonstrated that staff considered the guiding principle of least restriction. There were no blanket restrictions in place. For example patients could use their own mobile telephones on the ward and they had access to the internet. We found toilets and showers were kept unlocked and patients could access their rooms when they wanted. Patients in bedrooms on the first and second floor could use a lift to access their rooms with ease and all patients could access fresh air when they wanted.

The provider had recently adopted a new and validated approach to restrictive physical interventions, sometimes required in a mental health setting to protect a patient or staff from injury or assault. The approach taken by the provider recognised the frequency of restrictive interventions and focused on positive and safer approaches to managing challenging and risky behaviour. Staff ensured that before they made a decision to use a restrictive intervention that they had considered a less restrictive alternative first. This had proved beneficial on wards and staff told us that their detailed knowledge of individual patients often helped them to sensitively de-escalate difficult situations whilst maintaining the patients' dignity and self-respect.

# Long stay or rehabilitation mental health wards for working age adults

Good 

The hospital did not use seclusion as an intervention and there was therefore no seclusion room. There had been no cases of long-term segregation used in the 12 months prior to our inspection.

For the six month period 1 April 2019 to 1 October 2019 clinical staff at John Munroe Hospital had used physical restraint on 116 occasions with 35 individual patients. None of these incidents of restraint were in the prone position. All staff requiring training in least restrictive practices had been trained in non-prone restraint. Reviews of care records and interviews with staff showed that staff understood the definitions of restraint and practice set out in the Mental Capacity Act.

The organisation had a rapid tranquilisation policy that met National Institute for Health and Care Excellence guidance. The provider had used urgent sedation, known as rapid tranquilisation on 14 occasions in accordance with its policy.

## Safeguarding

Staff we spoke to could give examples of how to protect patients from harassment and discrimination. They understood what protected characteristics were under the Equality Act and knew when and how to make a safeguarding referral to their manager and to the local authority safeguarding board. Staff we interviewed understood and complied with the providers safeguarding policies.

Staff knew how to recognise different forms of abuse and how to identify adults and children at risk of, or suffering from, significant harm. There was also a policy for ensuring that children could safely visit wards if required.

## Staff access to essential information

Staff used paper care records for all their patients and kept daily notes on an electronic patient record system. The electronic versions of clinical information needed to deliver patient care were available to all staff except for clinical support workers who only had supervised access to the electronic daily record. The provider told us they were considering the options to resolve this as they recognised that lack of support worker access to the electronic care records restricted enhanced communication between key staff. However all essential information was passed over at

handover meetings. One of the options under consideration was to provide electronic tablets to support staff. Support staff did have complete access to the paper care records.

## Medicines management

The provider had sustained the improvements in medicines management since the last focussed inspection. This included arrangements for the storage and administration of medicines and medicines reconciliation, the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use. The information was obtained from a variety of sources such as: medication brought to hospital by the patient, GP surgery patient records, repeat prescription slips, hospital case notes. The list included name, dosage, frequency and route of administration.

Staff reviewed the effects of medicines on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance. This included monitoring physical symptoms, in line with the guidance relating to high dose anti-psychotic drugs, monitoring, lithium levels, clozapine blood tests and physical health checks following incidences of rapid tranquilisation.

Staff completed weekly medicines audits and the local pharmacist also completed clinical audits on a bi-monthly basis for each ward.

The provider had recorded six medicines errors in the six months preceding the inspection. These errors concerned medicines not being given at the prescribed time. Nurses responsible for these errors were given appropriate and supportive supervision to help prevent such errors in the future. Learning from these errors was also shared across all wards within the hospital.

## Track record on safety

The provider informed us of two serious incidents in the 12 months preceding the inspection. One involved a patient self-harming and the other was an overdose of an over the counter drug. The provider followed its duty of candour policy to ensure it was open and honest with patients and their families if something did go wrong and which could have caused or could have led to significant harm.

## Reporting incidents and learning from when things go wrong

# Long stay or rehabilitation mental health wards for working age adults

Good 

The provider told us that all incidents were recorded on paper incident forms. The nurse in charge signed these forms once care plans and risk assessments were updated appropriately. The clinical nurse manager or registered manager then graded the incident and decided whether the incident required a referral to the local authority safeguarding team. All incidents were a standing agenda item at the ward daily meetings and staff made recommendations for further investigation if required. Ongoing monitoring of incidents took place using the hospital's electronic records system where additional information, actions and outcomes could be added. Further longer term examination of lessons learned from incidents took place at the weekly leadership meeting, the monthly local governance meeting and monthly John Munroe Group clinical governance meetings. Learning lessons was also discussed as part of the providers staff induction training. Staff told us they knew what incidents to report and how to report them. They also said that serious incidents were investigated promptly and that they understood the need to be transparent in their discussions with patients when something went wrong. The inspection team found that staff were fully supported at meetings and in supervision with clinical managers when incidents occurred. We found evidence of changes made from lessons learned and saw improvements in safety as a result of feedback. This included medicines reviews of patients to assess whether a change in drug regime would support positive behaviour change.

**Are long stay or rehabilitation mental health wards for working-age adults effective?**  
(for example, treatment is effective)

Good 

## Assessment of needs and planning of care

We reviewed 12 care plans and in five cases these plans were detailed and included the needs of patients identified at assessment. Patients had received a copy of their care plan and we found they were holistic in approach to care and had evidence of mental and physical health care assessments. These assessments were completed at admission or soon after and staff updated these in a timely

manner. However, we found that the remaining seven sets of care notes, whilst containing evidence of previous reviews and patients' views, were not holistic or recovery orientated.

## Best practice in treatment and care

Staff used recognised rating scales to assess and monitor outcomes including the Health of the Nation Outcomes Scale to identify suitable care pathways and assess progress. Seven of the 12 care plans we examined met National Institute for Health and Care Excellence guidance by demonstrating that a range of care and treatment interventions were provided to patients. This included psychological and occupational therapy interventions which included cognitive and solution focussed therapies with a focus on rehabilitation. Staff ensured that patients had good access to physical healthcare, including access to a GP, a nurse and further specialists when needed. Staff also completed and recorded physical health monitoring and we saw evidence of this in patients' care records where staff had used a validated scale to monitor patients' vital signs. Staff participated in clinical audit, benchmarking and quality improvement initiatives which recently included a high dose antipsychotics audit to determine the prevalence of prescribing and to reduce this where necessary.

## Skilled staff to deliver care

All interventions provided by John Munroe Hospital were carried out by skilled and qualified staff. These staff included doctors, psychologists, nurses, occupational therapists and clinical support staff. All staff employed by the provider, including bank and provider owned agency staff had awareness training in dementia from the John Munroe Group training department as part of their induction. Staff on Rudyard ward had additional specialist training in the care of people with dementia. The hospital had also recently adopted a Positive Behaviour Support approach to assessment and care planning that focused on patient's needs, their environment and quality of life. Staff told us that the quality of induction, and follow up training provided was of high quality and that managers ensured that they had regular meetings to reflect on their clinical practice.

To further assess the skills of staff the inspection team used the Short Observational Framework for Inspection to assess the experiences of those patients with dementia on Rudyard ward. This assessment tool is used when patients

# Long stay or rehabilitation mental health wards for working age adults

Good 

have difficulty in expressing their thoughts and feelings and was developed to map care within dementia services. Our assessment confirmed our initial observations that staff interactions with patients were either neutral or good. This meant that there was observational evidence of staff positively engaging with patients. However patients with communication difficulties were sometimes responded to passively by staff and left to their own devices when a more positive interaction was possible. No staff interactions with patients were observed to be poor.

The provider managed poor staff performance promptly through supervision and appraisal and through performance management policy and procedure. The provider had a supervision completion target of 80% although data showed that across all wards supervision completion rates were above 90%. An examination of personnel files also showed that staff received regular formal appraisal of their work and performance. The provider told us that all staff appraisals that were due had been completed.

Staff on all wards had access to the full range of specialists required to provide high quality clinical care. This included recently expanded psychological and occupational therapy teams. Leaders of these teams told us that the organisation had made significant improvements in their governance structures to support the prioritisation of therapeutic work. Staff received sensory work training, to support patients in managing their distress and agitation as well as training in facilitating patient group discussion and activities. The lead psychologist also conducted psychological formulation with staff to further their understanding of the background to patients problems, to help them decide and reflect on the interventions required to support patients in improving their mental health. Staff on Rudyard ward had received additional training to support their work with patients with dementia.

## **Multi-disciplinary and inter-agency team work**

Clinical staff held regular multidisciplinary team meetings and the inspection team observed good communication between staff members of all disciplines. Ward handovers, led by the nurse in charge took place twice per day and staff discussed patients presenting problems for staff on the next shift to consider. Minutes of these handovers and other relevant information was also passed to the local GP and a practice nurse where appropriate. In addition clinical information was shared with care coordinators and

external professionals during regular Care Program Approach meetings where patients care was monitored and changing needs planned for. The psychology team worked closely with the occupational therapy and activities teams and shared the same building. This integrated team focused on formulation and treatment from admission to discharge and we were shown detailed pathways for this for both dementia and rehabilitation. Staff told us this approach had taken time to develop but they were of the opinion that they now had more support from management to improve their evidence based care planning and treatment. The team were confident that all patients were considered for different care approaches and that this was routinely reassessed throughout a patients stay at the hospital.

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

All staff had had completed mandatory training in the Mental Health Act and staff we spoke with had a good understanding of the Code of Practice and its guiding principles. After each teaching session on the Mental Health Act each member of staff was given a multiple choice competency questionnaire to test their knowledge. Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. There was a clear process for monitoring and checking Mental Health Act paperwork. Staff knew who their Mental Health Act administrator was and commented that they were always available to support them. Staff also had access to a reference folder with up to date Mental Health Act policies. Patients had their rights given to them every month. This was timetabled for each patient and the inspection team saw this documented in care records. Staff stored copies of patients' detention papers and section 17 leave forms correctly so that they were available to all staff that needed access to them.

Patients had access to information about independent mental health and advocacy and this was displayed on all wards. No information was available on Kipling ward on how patients could complain. Staff also ensured, where legally appropriate, that patients were able to take Section 17 leave from hospital. The Mental Health Act administrator carried out checks on this and other regular audits of

# Long stay or rehabilitation mental health wards for working age adults

Good 

Mental Health Act paperwork to demonstrate the providers compliance with the MHA and MHA code of practice. The hospital also displayed a notice to tell informal patients that they could leave the ward freely.

Recent examples of clinical audits carried out by the provider in the 12 months preceding the inspection that demonstrated compliance with the Mental Capacity Act included audits of Section 58, Treatment, Section 132, Rights, Section 17, Leave authorisation forms and leave risk assessment and a Deprivation of Liberty Safeguards documentation and application review.

## Good practice in applying the Mental Capacity Act

All clinical staff had received mandatory training in the Mental Capacity Act and staff we interviewed demonstrated an understanding of its statutory principles. This meant that staff knew when patients lacked capacity and made decisions in their best interests. They did this whilst recognising the importance of the person's feelings, culture and history. Staff also took all practical steps to enable patients with impaired mental capacity to make their own decisions and we saw evidence of this in the care notes.

The provider had an up to date policy on Mental Capacity Act and Deprivation of Liberty Safeguards and staff told us that they knew where to get advice regarding the Act. At the time of inspection there was one patient with a Deprivation of Liberty Safeguards application in process. The organisations Mental Health Act administrator monitored the progress of all Deprivation of Liberty Safeguards applications.

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

Good 

## Kindness, privacy, dignity, respect, compassion and support

John Munroe Hospital staff's interactions with their patients was warm and compassionate. Staff demonstrated high levels of understanding of the complexity of patients problems and spoke perceptively about the patients they cared for. staff made efforts to support patients to understand, manage and become

involved in their care. Clinical support workers knew their patients well and we saw examples of how they took the time to help patients understand each other's likes and dislikes. This helped reduce conflict on the wards. Staff discussed confidentiality and information sharing with patients and staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. The provider also undertook periodic patient surveys on specific topics.

## Involvement in care

### Involvement of patients

The provider told us that patients were involved in the planning of their care through care plans, risk assessments, multidisciplinary team meetings, Care Program Approach meetings, patients monthly meeting, one to one sessions with key nurses and regular interaction with care staff. Patients were encouraged to express their views and the provider conducted patient surveys from which action plans were generated and completed. We saw evidence in care records of staff encouraging the involvement of patients in their care and patients we spoke to told us they felt well cared for and consulted by staff.

Patients were consulted on work within the hospital including its decoration and the placement of art work on the wards. Feedback received from patients was actively encouraged by the provider.

An independent advocacy service was available to patients and staff made regular referrals to them. The advocacy service also visited the hospital when patients requested their support. Posters advertising the advocacy service were displayed on wards.

### Involvement of families and carers

Where patients gave permission, staff informed and involved families and carers appropriately and the provider gave opportunities for families and carers of patients to give feedback to staff. The provider had also received compliments from relatives of patients on the care they had provided.

John Munroe Hospital provided carers with information about how to access a formal carer's assessment. Where a need was been identified, discussions were held with the

# Long stay or rehabilitation mental health wards for working age adults

Good 

patient's care coordinator to arrange or facilitate a carers assessment. Carers were also supported to attend multidisciplinary team meetings with their relatives where appropriate.

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

Good 

## Access and discharge

The hospital prioritised liaison with patients and carers before admission, made sure there were no long delays and tried to ensure that the dates and times of admission were most suitable to the needs of the patients and their carers. Patients and carers could visit the hospital before admission if required and on admission they were given a tour of the ward and the hospital facilities to help familiarise themselves with the environment.

The provider was funded by 15 different commissioners and all except one were from outside of the hospital area. The average length of stay for the 24 patients discharged within the preceding 12 months of the inspection was between 975 and 1434 days across all wards. The longer lengths of stay were predominantly for patients with forensic histories. Average bed occupancy was 100% throughout the hospital and it had not had any delayed discharges in the preceding 12 months of the inspection. When staff discharged patients, they planned for this and patients were discharged at an appropriate time of day. There were no cases of any patient not having a bed when they returned from leave and patients were only moved between wards for clinical reasons.

If a patient's mental health became difficult to manage in the hospital environment due to increased distress or challenging behaviour the provider referred the patient to an acute ward for a period of care. In rare cases when a patient's condition required higher staffing levels than on a normal acute admission ward the provider made a referral to a Psychiatric Intensive Care Unit. Both types of referral were efficiently and collaboratively managed with family, care coordinators, clinical commissioning groups and other relevant authorities. The provider had established good

working relationships with its commissioning authorities and where there had been delays in a bed being located, the provider managed the patients safely at John Munroe Hospital on higher levels of observations until the patient could be safely transferred.

## The facilities promote recovery, comfort, dignity and confidentiality

All wards were single sex accommodation and patients had their own bedrooms that were left open at all times. However, patients could lock their own rooms. They could also personalise their bedrooms and the inspection team saw examples of how patients had placed pictures and other personal belongings within their own personal space. Patients also had somewhere secure to store their possessions. The provider had completed a patient consultation on the décor of communal areas in Kipling and Horton wards and the inspection team were told this work would be commencing soon. Patients had access to outside space and could enjoy the well looked after grounds.

A dedicated garden area had been created to allow the patients with dementia on Rudyard to have safe access to the outdoors. Safe level access and soft flooring options had been chosen to reduce falls risks. Planting choices had been made to emphasise the positive sensory impact of being outdoors.

Other changes had been made within Rudyard ward to create a dementia friendly environment with bright wall coverings to stimulate memories being used in the social areas. Throughout the hospital dementia friendly signage had been used to emphasise through words and pictures the purpose of rooms and facilities.

However; on some wards corridors were very narrow and on Larches ward the general environment was dark and gloomy. This ward based in a bungalow also only had one patient toilet which included a shower. Therefore if the shower was in use there was no patient toilet available for use. The provider told us there were plans in place to add another patient toilet.

Within the main hospital we found that a female patient based on Kipling ward had a bedroom on the stair landing room adjacent to Rudyard Ward which compromised her privacy and dignity. This was because access to the toilet and other facilities was through the male ward. This meant the patient had to use the nurse call system to then be

# Long stay or rehabilitation mental health wards for working age adults

Good 

escorted by staff to use the facilities. Following feedback on the day of the inspection the provider took immediate responsive action to remedy this and moved patients so that the problem no longer occurred. This movement of patients caused little disruption to the patients and the operations of the hospital.

Staff told us that space for their work was limited and that this restricted treatment options. This was mainly due to the noise from the newly appointed staff room next to the therapy room. However, staff and patients had access to other rooms and equipment to support treatment and care. This included clinic rooms to examine patients and activity and therapy rooms. The occupational therapy team offered activities including activities of daily living to help patients develop their skills in basic tasks. Discussions with staff revealed an insightful approach to long term rehabilitation and treatment that recognised the importance of specialist assessment, treatment, interventions and support. Staff understood that care should be personalised and often began with small but significant interventions to help patients regain trust, skills and confidence. Staff worked in partnership with patients and carers to achieve a collaboration to patient care.

The provider had surveyed patients for their opinions on meals. The survey results showed that showed patients enjoyed the food served following changes to the menu made in consultation with patients. Patients could also make hot drinks and snacks throughout the day and were offered support to do so if required or if a risk assessment indicated this.

## Patients' engagement with the wider community

The provider accessed vocational courses from, and established good networks with local colleges to ensure improved access to education for patients. Education programs were also in place for long term rehabilitation patients at the hospital to support them in developing their CV's and help them approach employers. Some patients had been successfully employed in local cafes, charity shops and supermarkets. Staff also supported patients to access the local community using its hospital vehicles including a specially designed vehicle for patients with differing abilities. Days out included home visits and group leisure excursions. Helping patients to use public transport independently, to and from the hospital, was too difficult to achieve because of its isolated location.

Staff supported patients to maintain contact with their families and carers. Whilst families and carers were not routinely in attendance at multidisciplinary team meetings staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the hospital and the wider community. Information with carers and families was shared, with patients permission, at follow up meetings or by telephone.

## Meeting the needs of all people who use the service

The hospital made adjustments for patients with disabilities and most wards were accessible to patients with disabilities and wheel chair users. There were also adapted hygiene facilities. However, it was difficult to manoeuvre wheel chairs in the narrow corridors of Rudyard ward. In addition wheel chair users might have found difficulty in preparing food and drinks on the high work tops when sitting in a wheel chair.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, accessing advocacy, how to make a complaint and on how to contact CQC. However, the availability of information varied from ward to ward. Limited information was on display on the Larches ward in particular. Staff told us that patients' specific communication needs were met when needed and that they had access to interpreters and signers as required. Patients with dietary needs were catered for adequately and priority was given to patients personal food choices. Staff demonstrated an understanding of patients religious and cultural needs and worked closely with a local religious groups to meet the needs of patients. Information provided to patients was accessible and we found examples of information in easy-read form for patients that needed it.

## Listening to and learning from concerns and complaints

The provider received a total of nine complaints in the 12 months preceding the inspection. None of these were referred to the ombudsman and four were partially upheld and resolved satisfactorily on site. The provider had a complaints procedure and patients said they knew how to complain and raise concerns. The registered manager also provided feedback to patients about complaints at regular meetings. Staff told us that all feedback they received was considered and acted upon appropriately. This included a patient complaint that their bedroom view was blocked by

# Long stay or rehabilitation mental health wards for working age adults

Good 

a newly erected fence. The outcome of this complaint was that a window was put into the fence. Another complaint of a member of staff being rude was partially upheld and resulted in the staff member offering an apology, which the patient then accepted.

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

Good 

### Leadership

Leadership at John Munroe Hospital included the board members, chief executive, hospital owners and quality lead, and the registered manager and clinical nurse managers. All had the skills, knowledge and experience to perform their roles and had a good clinical understanding of caring for patients with dementia and providing long term rehabilitation for a wide range of other patients. Leaders we spoke to were able to describe clearly how their staff worked to provide high quality care. This included listening to, and acting on feedback from patients and staff, and on learning from audit and governance programs. Staff knew who John Munroe Hospital's senior leaders were and knew them by name. The registered manager had encouraged and enhanced communications between staff and leaders and most clinical staff we spoke to were positive about the changes that were now in place. These changes include regular morning governance and board to ward meetings.

### Vision and strategy

John Munroe Hospital's vision and values were to accept the individuality of patients and to empower them through promoting individual choice. The provider also had a commitment to non-discriminatory, safe and fair practice that followed equality and diversity principles. The hospital's stated aim was also to employ high quality, caring and motivated team members with an interest in continuous professional development. Staff we met told us that they understood these values and agreed with them. The inspection team noted that staff were able, at all levels,

to describe their practice as it related to the vision and values of the organisation. Staff also said that they felt able to contribute to discussions about the strategy for John Munroe hospital during a period of change.

### Culture

Staff described a renewed organisational openness to therapeutic interventions and a multi-disciplinary team approach to care that incorporated the evidence base for mental health patients. Staff were concerned that staff turnover had been high and that long term patients had not benefitted from this. However staff said that the arrival of new, keen and caring staff was welcome and that change resistant staff were now the minority. Staff also felt that outdated professional attitudes to the treatment and care of patients with mental health problems was diminishing within the organisation.

Staff we spoke with felt respected, supported and valued and said board members were available at a local level to support, identify concerns and offer solutions. Recent feedback at a board meeting was that staff felt more supported and able to be open and express their views and feelings with senior management. The board had also developed ward level champions for training, infection control and managing restrictive practices. The provider reported that this and other initiatives had boosted staff morale and promoted career progression and continued professional development across the staff teams.

Managers dealt with poor staff performance when needed and the registered manager reported no bullying or harassment cases. The complexity of the hospital's patient group required motivated and resilient staff and the provider told us that this had been difficult to sustain. However they continued to identify and nurture staff with the right attitudes and values. Psychological support, debrief and reflective practice sessions were available to all staff across every ward.

There were two 'Freedom to Speak up Guardians' whose role was to encourage staff to speak with others about patient safety and the quality of care. The provider also had a whistle blowing policy in place to protect staff if they wished to express concerns about clinical and organisational practice.

### Governance

# Long stay or rehabilitation mental health wards for working age adults

Good 

John Munroe Hospital had continued to progress its improvement plan and deliver on key components. Its interim quality and performance report outlined improvements in staff recruitment and retention and the successful development of the of clinical nurse manager roles. There was also a renewed focus on managing conflict, training and competency for all staff including internal bank and agency staff. The provider had also developed an internal estates improvement programme.

The inspection team found the provider was committed to continuous quality improvement and clinical governance. This included the intended completion of the NHS information governance toolkit and the formulation of an accident and incident data base, to support the monitoring of themes and trends. The provider informed us that it had achieved some key quality priorities since the last inspection. These included integrating clinical evidence into its policy reviews and placing greater emphasis on the transparent flow of information throughout the organisation to help promote staff trust and ownership of developments. There had been a continued emphasis on the governance of the hospital's medicines management system and the improvements made at the last inspection had been sustained. Other initiatives included the appointment of an internal 'environmental champion' to lead on reducing environmental risk and the implementation of the new validated training for staff in the management of risk, restraint and aggression.

The provider had developed a new clinical staffing model which ensured that its hospital wards were adequately staffed and that these staff were trained, supervised and treated patients well. There had also been a recent arrival of new staff to permanent positions on the wards and we found no staffing problems at inspection. New staff we spoke to were aware of the clinical direction of the hospital and had a common understanding of the aims of care within it. The use of bank or regular agency staff was to cover sickness and emergencies when they occurred.

The inspection team observed that staff demonstrated professional enthusiasm for the future of therapeutic interventions at John Munroe Hospital and for the development of its rehabilitative program. Staff welcomed new initiatives such as the morning governance meetings and leaders openness to new ideas and thinking. The provider had established and was sustaining a clear framework for discussion and learning.

## Management of risk, issues and performance

Staff maintained and had access to the risk register at ward and board level and could escalate concerns when required. Both clinical staff and hospital leaders had a common understanding of the risks. This included the identification of the greater demands on staff due to the increase in the referral of patients with complex problems. Some patients were on high observation levels necessitating higher staffing levels and the use of agency staff on some wards. Safer staffing had been the subject of most concerns raised by staff. However frequent discussion instigated by the registered manager helped to promote joint solutions and a common understanding of the issues.

The provider recognised that its location in winter could cause staffing emergencies if the weather was severe. A contingency business plan was therefore developed to provide 4x4 transport to bring staff in to work, and to help them home, if required.

## Information management

Managers collected data from the electronic systems that staff used to record all client information. All staff had access to the equipment and information technology needed to do their work apart from clinical support workers who did not have unsupervised access to the electronic patient record. The electronic client case file system was comprehensive and included confidentiality of client records. Staff told us they found it easy to use, and was secure.

Managers had access to information to support them with their management role. This included audits and action plans shared within the hospital and discussed at clinical governance meetings. Data and information on safeguarding, incidents, the Mental Health Act, patient experience, complaints and human resource issues was collated and managed efficiently and used to support staff to meet the demands of their roles.

## Engagement

The inspection team were told that the board had proposed that a patient and staff representative were invited to attend board meetings. In addition the hospital had a web site to provide staff, patients and carers with to up-to-date information about their work and the services the hospital provided.

# Long stay or rehabilitation mental health wards for working age adults

Good 

Users and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Posters were available that advised patients on how to give feedback and a website also provided a portal to submit enquiries.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements to the care of patients. These improvements included plans to improve the decoration of the building and the renewing of equipment. The provider used patient surveys to support their involvement in decision-making.

## **Learning, continuous improvement and innovation**

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes through various forum including the daily planning meetings.

Innovations were taking place within the hospital which included the development of the link nurse trainee nurse associate programme, designed to help bridge the gap between health care assistants and registered nurses. The provider was also working with Keele University on preceptorship to support newly registered nurses.

All staff were encouraged to use the new governance and quality improvement methods to improve their practice.

Staff regularly participated in audits including infection control and medicine management.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that staff always develop holistic and recovery orientated care plans informed by a comprehensive assessment.

### Action the provider **SHOULD** take to improve

- The provider should ensure that care support workers have access to the daily electronic patient record.

- The provider should ensure there is a comprehensive range of accessible information on mental health problems, treatments, physical health problems, how to access primary care, smoking cessation, local services, help Lines, how to complain and information on who is in charge of the ward.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p><b>Regulation 9</b> HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Person-centred care</p> <p>Staff did not always develop holistic and recovery orientated care plans informed by a comprehensive assessment. Staff did not design care or treatment with a view to achieving patients preferences and ensuring their needs were met</p> <p>This was a breach of regulation 9(3)(b)</p>