The Priory Hospital Chelmsford

Quality Report

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
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.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We rated the Priory Hospital Chelmsford overall as 'requires improvement' because:

• The provider's governance systems were not fully effective in monitoring the service provided. Two issues related to ligature assessment and management and male visitors to Chelmer ward.

• Some ward environments required improvement. The children and adolescent mental health services (CAMHS) ward did not meet the standards outlined in the (QNIC) Quality Network for Inpatient CAMHS, the Royal College of Psychiatrist's peer review 2017. Managers identified some improvements required, but did not set timescales for completion.

• The provider had not fully complied with eliminating mixed sex accommodation as ward staff had allocated a bedroom in the male area of Danbury ward to a female patient, which affected their dignity and privacy. Bedrooms on the ground floor did not have privacy screening on windows. Danbury ward's fence in the women's garden posed an absconsion risk as patients could potentially climb over. Staff told us that some patients had absconded from the external gardens. Chelmer and Springfield ward staff had not completed personal emergency evacuation plans for patients.

• The provider had not ensured that all staff were receiving supervision as per their standard of 90%. The provider's recruitment and human resources processes were not fully effective as there were several nursing staff vacancies, which managers said was one of their challenges. Wards used a notable level of agency staff, particularly on the CAMHS ward that were not regular and managers were not regularly reviewing their training. Staff had not covered 33 nursing shifts from September to January 2018.

• Managers had not ensured that all staff had access to report incidents in a timely way. They were not fully reviewing those incidents reported to check the quality and identify risks and areas for improvements.

• Staff on Chelmer and Danbury wards had not fully completed initial assessments in six patients' records. They had not always recorded their observation of patients.

• Chelmer staff had not recorded if blood borne virus testing was offered to patients being treated for addictions and had not documented if they had a history of intravenous drug usage.

• The provider had not given clear information to informal patients on Danbury and Chelmer wards as to when they could have community leave. Eight patient's records did not have information about discharge planning. The Lodge residential rehabilitation service for patients receiving treatment for addictions was not fully open. This meant that patients who had finished detoxification on Chelmer ward did not move to the service.

• Staff's practice concerning management of medicine on Chelmer and Danbury ward's needed improvement, for example, we found gaps in records.

However:

• Patients told us that staff were caring, treated them with dignity and respect and gave them support. Most patients said they were involved in their care and treatment. Carers said that staff contacted them to gain their views.

• The provider held daily 'flash' meetings with staff and completed 'quality walk rounds' by senior staff, patients and staff to record the quality of the hospital.

• The provider had a system for investigating and responding to complaints. The provider had received 38 compliments about its service.

• Most staff reported effective team working, support and good morale. Staff had received mandatory training for their role. Managers had completed 100% of appraisals with staff.

• The provider had employed more doctors, including a specialist in working with patients with addictions.

Summary of findings

• The provider had taken action to ensure patients with addictions had drug testing and appropriate assessments to establish withdrawal and inform treatment for detoxification.

• The provider could offer a range of therapies recommended by the National institute for health and care excellence. This included cognitive behavioural therapy and dialectical behavioural therapy.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 	Danbury, Chelmer and Springfield wards
Child and adolescent mental health wards	Requires improvement 	CAMHS ward

Summary of findings

Contents

Requires improvement

The Priory Hospital Chelmsford

Services we looked at

acute wards for adults of working age and psychiatric intensive care units; child and adolescent mental health wards; specialist eating disorders services and substance misuse/detoxification.

Summary of this inspection

Background to The Priory Hospital Chelmsford

Priory Healthcare Limited is the registered provider for The Priory Hospital Chelmsford, an independent mental health hospital providing 60 beds.

The Care Quality Commission registered The Priory Hospital Chelmsford to carry out the following regulated and activities:

• Treatment of disease, disorder or injury

• Accommodation for persons who require treatment for substance misuse

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Diagnostic and screening procedures.

The service has a registered manager and a controlled drugs accountable officer.

The services at this hospital include:

Acute wards for adults of working age:

• Chelmer ward, a 16 bedded mixed sex acute ward for assessment and treatment of patients with mental health needs and addictions.

• Danbury ward, a 12 bedded mixed sex acute ward providing in-patient beds for assessment and treatment of patients with mental health needs. (This ward opened in July 2017).

• Springfield ward, a 12 bedded mixed sex ward providing assessment and treatment for patients with an eating disorder.

• The Lodge, a three-bedded mixed sex house for patients receiving the addictions therapy rehabilitation programme.

Child and adolescent mental health wards (CAMHS):

• CAMHS ward, a 17 bedded mixed sex ward providing assessment and treatment for children and adolescents with mental health needs.

Outpatient service:

• The provider also provides mental health assessment and treatment on an outpatient and day patient basis. We did not inspect these services.

There have been five inspections carried out at The Priory Hospital Chelmsford since registration in 2011.

The CQC last inspected this location on 6 December 2016.

We identified the following breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 : 12 safe care and treatment; 10 dignity and respect; 17 good governance and 18 staffing. We checked on the actions that the provider stated they would take to ensure compliance. We found that the provider had taken some actions to address issues raised. However, we have identified further breaches of these regulations, which we have reported on.

Summary of this inspection

Our inspection team

An inspector led our inspection team from the mental health hospitals directorate.

The team that inspected the service included three CQC inspectors, two inspection managers, two specialist advisor nurses with experience of working with child and adolescents with mental health and specialist eating disorders.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all four wards at the hospital, The Lodge and day hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 17 patients who were using the service
- spoke with six carers
- spoke with the hospital director/registered manager and other members of the senior management team
- spoke with the managers for each of the wards
- spoke with 23 other staff members; including doctors, nurses, an occupational therapist , therapy staff and a social worker
- spoke with an independent advocate
- attended and observed seven meetings: a staff hand-over meeting; three multi-disciplinary meetings; a community meeting, a care review meeting and a 'mutual help' meeting
- looked at 26 care and treatment records of patients
- looked at 19 records relating to staff
- carried out a specific check of the medication management on two 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

• Sixteen patients told us that staff were caring, treated them with dignity and respect and gave them support for their individual needs, which helped them in their recovery.

• They told us they had opportunities to give feedback on their care and the service provided at multi-disciplinary meetings and other patient forums.

• Twelve patients said they were involved in their care, treatment, and care planning.

• Most patients were satisfied with the activities offered, particularly on Chelmer and Danbury wards.

• Ten patients were satisfied with the cleanliness of the wards and the environment.

Summary of this inspection

• Two young people were positive about the educational support they received.

• Carers said that staff contacted them to gain their views. They said staff were caring.

However:

• Seven patients expressed concerns about the ward environment, for example for refurbishment and cleanliness issues.

• Six patients said there should be more treatment or activities offered to them.

• Four patients said staff asked them to sign their care plan just before the CQC visit without real involvement.

• Four patients and three carers stated that the provider could improve staff communication with them about care and treatment issues.

• Two patients said they did not see their keyworker on a regular basis.

• Two young people said that night staff were less caring than day 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?

Requires improvement 

We rated safe as 'requires improvement' because:

- Staff did not have access to information about all the ligature risks and blind spots for their ward. Some ward environments required improvement. The Child and Adolescent Mental Health Services (CAMHS) ward did not meet the standards. There was no specific de-escalation space on the CAMHS ward for staff to use when young people were distressed or agitated. Managers identified some improvements required, but did not set timescales for completion.
- The provider had not fully complied with eliminating mixed sex accommodation as ward staff had allocated a bedroom in the male area of Danbury ward to a female patient, which affected their dignity and privacy. Danbury ward had a fence around the external garden. However, staff told us that some patients had absconded from the hospital by climbing over this fence. Chelmer and Springfield ward staff had not completed personal emergency evacuation plans for patients
- The provider had not recruited to all nurse vacancies. Staff were not available to cover 33 nursing shifts from September to January 2018. Managers relied on high use of bank and agency, particularly on CAMHS and Danbury wards. They did not always block book regular staff.
- Staff were not always reporting incidents in a timely manner as not all staff had access to the systems. Managers were not reviewing incidents effectively to identify where they needed to take actions to reduce the reoccurrence. Staff had not fully updated risks in four patient's records on Chelmer and Danbury wards. Staff had not always recorded their observation of patients.
- Staff gave informal patients on Danbury and Chelmer wards mixed messages as to when they could have community leave. Staff were still leaving male visitors unsupervised in the women's area on Chelmer ward, which could affect their safety, privacy and dignity.
- Staff's practice concerning management of medicine on Chelmer and Danbury wards needed improvement, for example, we found gaps in records.

However:

- The hospital had a 4% staff sickness rate in a 12-month period. This is less than the average for NHS trusts (4.2%).

Summary of this inspection

- The provider held daily 'flash' meetings to monitor risks for the wards.
- The provider had employed more doctors, including a specialist in working with patients with addictions.
- Staff had received mandatory training for their role.
- The provider had taken action to ensure patients with addictions had drug testing and appropriate assessments to establish withdrawal and inform treatment for detoxification.

Are services effective?

Requires improvement

We rated effective as 'requires improvement' because:

- Staff were not receiving regular supervision for their role as per the provider's standard of 90%. This posed a risk that supervisors were not regularly offering support to staff and were checking staff were carrying out their role appropriately.
- Staff had not fully completed six patients' initial assessments on acute wards. Which posed a risk that staff would not meet all patients' needs.
- Chelmer staff had not recorded if blood borne virus testing was offered to patients being treated for addictions and had not documented if they had a history of intravenous drug usage.
- Staff were not measuring outcomes of the effectiveness of the treatment they gave to patients for addictions.

However:

- Managers had completed 100% of appraisals with staff.
- The provider could offer a range of therapies recommended by the National institute for health and care excellence. This included cognitive behavioural therapy, dialectical behavioural therapy.
- Springfield ward staff were assessing patients' nutrition and hydration needs. Patients with eating disorders were on diet plans in accordance with the provider policy and the 'Management of really sick patients with anorexia nervosa' guidance.
- The provider employed a range of multi-disciplinary staff including nursing staff, consultants, doctors, occupational therapists, psychologists, counsellors and therapists and a social worker.

Are services caring?

Good

We rated caring as 'good' because:

- Patients told us that staff were caring, treated them with dignity and respect and gave them support, which helped them in their recovery. We confirmed this through our observations.

Summary of this inspection

- Staff had an understanding of patient's individual needs.
- The Child and Adolescent Mental Health Services (CAMHS) staff had specialist training to work with young people in accordance with five principles 'nurture, expectations, respect, enabling and reflection'.
- The provider had taken actions following our last inspection to offer patients copies of their care plans
- Staff involved patients in their care and treatment for example, gaining their views in multi-disciplinary meetings (ward rounds) and mutual help meetings.
- Patients had access to advocacy services.
- Patients were able to give feedback on the service they receive, for example through 'your say' forums.
- Carers said that staff contacted them to gain their views. They said staff were caring.

However:

- Five patients said there should be more treatment offered to them.
- Four patients said staff asked them to sign their care plan just before the CQC visit without real involvement.
- Four patients and three carers stated that staff improve their communication with them about care and treatment issues.
- We did not see that patients had advance decisions in place, detailing how they wanted staff to treat them when their mental health deteriorated.

Are services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- The ward had 17 beds and this was above the national average bed number for inpatient CAMHS. The QNIC report (2017) identified that the service should reflect on whether or not the number of beds is suitable for the amount of space on the unit.Young people said they did not regularly have easy access to fresh air. Despite plans to update and improve the environment, there were not specified timeframes for all changes.
- Some staff said there was pressure from the provider not to decline patients resulting in admitting patients with more complex needs. Danbury ward's admissions criteria excluded men with physical health difficulties. However, the provider had admitted a female patient with these needs.
- The Lodge residential rehabilitation service for patients receiving treatment for addictions was not fully open. This meant that patients who had finished detoxification on Chelmer ward did not move to the rehabilitation service.

Summary of this inspection

- Eight patient's records did not have information about discharge planning.
- The provider had not put privacy screening on Danbury's downstairs bedroom windows. Bedrooms could be looked into from the garden. Patients did not have keys to their rooms.
- The hospital's multi-faith room was not fit for the purpose of contemplation or prayer as staff often used it for other purposes.

However:

- Patients could personalise their rooms. Springfield patients displayed inspirational quotes to encourage patients with their recovery. Danbury ward had pictures on the ensuite room doors. Patients had access to safes to store their possessions.
- As part of the safe wards scheme, staff and patients had developed, a 'mutual help meeting' on Danbury ward.
- Staff maintained links with patients' community teams to assist them with discharge back to their home area as appropriate.
- The provider had a system for investigating and responding to complaints. The provider had received 38 compliments about its service.
- The Office for Standards in Education, Children's Services and Skills (OFSTED) inspected the CAMHS ward education department in March 2017 and rated the service as 'outstanding'.

Are services well-led?

Requires improvement

We rated well led as 'requires improvement' because:

- The provider's governance systems were not always effective. For instance, the provider had not fully addressed two issues from our 2016 inspection relating to ligature assessment and management and male visitors to Chelmer ward as we still found risks.
- Managers had identified the need to improve the ward environment, but there were not clear timescales for making all of these improvements. The Child and Adolescent Mental Health Services (CAMHS) ward did not meet the standards.
- Managers were not fully reviewing those incidents reported to check the quality and identify risks and areas for improvements.
- The provider had not taken action to ensure that all staff were receiving supervision as per their standard.
- The provider's recruitment processes were not fully effective as there were several nursing staff vacancies, which managers said

Summary of this inspection

was one of their challenges. Managers used a notable level of agency staff, particularly on the CAMHS ward that were not regular or familiar with the service and managers did not have a system for reviewing their training.
- The provider's staff survey April 2017 identified that staff's overall satisfaction was 63%. This was below the provider's overall results (77%).

However:

- Staff had an understanding of the organisation's values. The organisation linked its purpose and behaviours to staff appraisals and the new care certificate workbooks for staff.
- The provider used key performance indicators to gauge the performance of the team. Managers had oversight of staff training and had improved staff's compliance with this.
- Most staff reported effective team working, support and good morale.
- Staff knew how to use whistle-blowing process. They said they felt able to raise concerns without fear of victimisation.
- Staff gave feedback on services and input into service development, such as 'your say' forums. Senior staff, patients and staff completed 'quality walk rounds' to record the quality of the hospital.
- Springfield ward had received accreditation for the Quality Network for Eating Disorders (QED). Hospital accreditation assures staff, patients and carers, commissioners and regulators of the quality of the service provided.

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 had a system for staff to examine patients' detention papers on admission. The provider had appointed a MHA administrator and had an identified lead manager who they could contact with queries. The provider had a central team giving mental health act support to the hospital.

• Eighty percent of staff on these wards had training in the Mental Health Act. The provider had not identified this as a mandatory training subject for all staff.

• On Danbury, staff had not notified hospital managers of an incident relating to a obtaining a mental health assessment for a patient. Staff did not have a clear management plan for how to support the patient in the interim and were not clear about their legal responsibilities.

• Staff had attached copies of consent to treatment forms to medication charts where applicable. The provider carried out audits to check that staff were gaining patients' consent regarding their care and treatment. The provider carried out audits to check that the legal authority for admission and treatment was clear if a young person was detained under the MHA.

• The provider had systems for ensuring staff explained patients legal rights under the MHA explained to them on admission and routinely thereafter.

• Patients had access to an independent mental health advocacy service that visited wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

• The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over who are unable to make all or some decisions for themselves.

• No patients were subject to a Deprivation of Liberty Safeguards application during our visit.

• Ninety one percent of staff received training in the Mental Capacity Act.

• The provider had not identified this as a mandatory training subject for all staff.

• Staff discussed patient' consent and capacity to make specific decisions at multi-disciplinary reviews and we saw examples of this in four records. However, two young people's records held limited information.

• Staff referred to and completed 'Gillick' competence for young people. Staff need to assess if children under 16 years have enough understanding to make up their own mind about the benefits and risks of treatment – this is termed 'Gillick competence'. Eighty-two percent of staff who work with young people also had training regarding the 'Fraser' guidelines.

• Staff said that they would not ask patients receiving treatment for addiction to sign treatment contracts whilst intoxicated.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe and clean environment

• Chelmer ward staff did not have access to the latest ligature risk assessment. It did not have all the information available to manage the risks. For example, staff had not identified wardrobe door hinges on the ligature risk assessment. Managers had not ensured that staff had easy access the latest ligature assessments on the ward. Some areas with risks were missing such as the kitchenette. Springfield and Chelmer ward staff did not have copies of external area ligature assessments. Staff took action to address these issues during our visit. The provider had taken some actions to ensure ligature risk assessments identified ligature points and were rated appropriately, although the documents were lengthy to read.

• The provider had identified they needed to improve bedrooms on Springfield and Chelmer to make safer for patients with higher needs. They had sourced options for reducing ligature risks and fitting anti barricade doors. However, there was no timescales for all these changes. Staff had restricted patient's access to Danbury ward stairwell due to identified ligature risks. This meant patients required escorting up and down stairs and staff had installed a doorbell to call them for this.

• Chelmer, Springfield ward layouts had blind spots where staff could not easily observe patients. The location of both ward offices did not enable staff to observe all parts of the ward. Staff had access to risk assessments with actions for staff to observe patients in the ward areas. However, the assessment did not capture an area in the kitchenette on Chelmer, which staff had identified as a risk. Chelmer ward did not have door vision panels for staff to check on patients. Springfield ward still had open corridor doors leading into Chelmer ward so it was unclear where Springfield ward ended and Chelmer ward started. When we asked the provider if patients moved freely between the wards, staff said they tended not to. However, Danbury ward was a purpose built ward designed for staff have to greater observation. Additionally close circuit television was installed in communal areas, which staff could check from the ward office.

• The provider had some systems to assess environmental risks. However, a patient on Springfield showed us they had tissue paper in window gaps to prevent drafts. We found a protruding screw in a Chelmer ward bedroom. Staff said they would take action to report and address these issues. Danbury ward had a fence around the external garden. However, Staff told us that some patients had absconded from the hospital by climbing over this fence.

• The provider had not fully complied with the Department of Health and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex accommodation. For example, staff had allocated a bedroom in the male area of Danbury ward to a female patient for greater staff observation and support. We asked if the provider had reported this as a breach of same sex accommodation to the Department of Health and did not get a response. However, patient's bedrooms had ensuite washrooms. Chelmer and Danbury wards had bedrooms for men downstairs and women upstairs. Staff told us if

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

they admitted male patients to Springfield ward then they would group their rooms together near the staff office. Women able to go upstairs had access to female only lounges.

• Ward staff were inconsistent in completing personal emergency evacuation plans for patients. For example, Chelmer ward's were out of date and Springfield ward only had summary sheets, which did not give details on how staff should support patients with mobility difficulties. Regular fire safety checks and fire drills took place.

• Staff had access to appropriate alarms and nurse call systems were available in every room.

• Ward areas were clean and had good furnishings. Staff adhered to infection control principles including handwashing. Staff had up to date cleaning records, which demonstrated they regularly cleaned the environment. However, staff could not show us a cleaning rota for toys in the day hospital. Staff had arranged to deep clean a bedroom on Chelmer ward due to damage by a patient. Wards had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that staff checked regularly.

• The provider had systems for ensuring staff maintained other equipment. Springfield ward manager had a system for monitoring patient's bedroom temperatures to ensure they were not too cold and could provide additional heaters. Staff told us that the provider had changed shower curtains to ensure they were collapsible at a weight of 20 kg. Danbury ward had detachable foam ensuite doors to reduce ligature points. However, Chelmer' ward's doorbell did not work properly which meant patients had difficulty contacting to staff to let them back in from leave.

Safe staffing

• The total nursing staff establishment was 24.4 nurses and 51.4 nursing assistants. As of November 2017, there were 15% staff vacancies with 18 nurse and six nursing assistant vacancies across the wards. Since then managers recruited three staff and was in the process of recruiting another two staff. Managers told us that they had temporarily closed The Lodge due to having insufficient staffing. They had identified recruitment and retention of band five nurses as one of their biggest challenges.

• The hospital had a 4% staff sickness rate in from December 2016 to November 2017. This is less than the average for NHS trusts (4.2%). There were 41 staff leavers (24%) over the last year.

• Springfield ward had one nurse and seven nursing assistant vacancies. The provider had identified the number and grade of nurses required for each ward. The staff to patient ratio was 1:3. Chelmer ward had one nurse and no nursing assistant vacancies. The staff to patient ratio was 1:4 patients in the day. Danbury ward had six nurse and eight nursing assistant vacancies. The staff to patient ratio was 1:4 patients in the day. Ward bed numbers were within the national recommendations for acute wards to ensure safety and privacy. There is no national guidance for staffing levels on wards, because staffing should depend on the patients' needs. Staff worked long days (11.5 hour shifts).

• The provider used bank (employed by the provider on an as and when basis) and agency staff were used to cover vacancies. In January 2018, agency staff (mostly Danbury ward) covered 246 nursing shifts and bank staff covered 107. Managers said they did not 'block book' staff for a specific period for wards, except on Chelmer ward.

• Staff did not cover 17 shifts from September to November 2017. There were 10 occasions where nursing staffing was below the provider's establishment, from a sample of staffing rotas checked for the previous six weeks on Danbury ward. There were six occasions when nursing assistant staffing was below expected numbers. However, managers had arranged staffing above the establishment levels at night. Chelmer manager said they often loaned staff to other wards to cover shortages. Four staff said staffing levels were insufficient. Two patients said they did not see their keyworker on a regular basis. Managers reviewed staffing daily in 'flash' meetings to determine the ward's needs and said they were able to adjust staffing levels daily to take account of patient's needs.

• Staff had systems to track the frequency of when patients had escorted leave. Most patients were not detained under the Mental Health Act 1983/2007, so did not require staffing escorts. Staff said staffing levels did not affect them from safely carrying out physical interventions with patients.

• After our last inspection, the provider had employed a specialist consultant doctor for patients receiving treatment for addictions. The provider had recruited other

specialist doctors across all wards. Springfield ward had a part time lead consultant for treating patients with an eating disorder. The provider had arranged for regular agency doctors to be on site out of hours. In a medical emergency staff would call '999 for an emergency service response.

• Over 80% of staff had completed mandatory training; this included basic life support training.

Assessing and managing risk to patients

• We checked 20 care records. Staff had completed the provider's risk assessment tool for every patient on admission and had updated them regularly. However, we identified four out of 20 occasions when Chelmer and Danbury staff had not fully detailed risk issues in patients' records. For instance, one patient's risk history did not detail their history fully regarding deliberate self-harm. Staff had taken a detained patient off section and had not clearly documented the rationale for this. In one patient's admission assessment, staff had not detailed the risk assessment for the patient having contact with their children. Staff had restrained an informal patient and there was no information in risk assessment or care plans regarding use of restraint, nor were there any positive behaviour support plans developed for the patient, which is recognised as national best practice.

• The provider reported three incidents of use of restraint June to November 2017, with two incidents for Chelmer ward. Staff had held one patient in prone position on Danbury ward for the administration of rapid tranquilisation medication by injection. Prone position restraint is when a patient is held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states that if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. Staff told us that they would not usually hold a patient in prone position to give an injection and instead showed us they placed the patient in a kneeling position.

• The hospital did not have a seclusion room. There had not been any seclusion or long-term segregation for patients in the last six months. If regular seclusion was required for a patient, staff would request a transfer for the patient to another service.

• Staff's records for observing patients were not always robust as we found errors in a sample of six records on Danbury and Chelmer wards. There were gaps when checks of patients were due, and staff had not detailed the location for one patient.

• Staff allowed male visitors to access female patients' ward areas without constant supervision on Chelmer ward. We considered this could pose a risk to the privacy and dignity of patients. We raised this issue at the last inspection. The provider had implemented a policy that visits in female bedrooms would be last resort and based on issues such as poor physical health. Staff would escort male visitors to and from the ward. We observed a male staff member escorting two male visitors from a female patient's bedroom. On this ward, a patient said a man had gone into the female lounge. Springfield female patients had raised concerns about unknown male staff from other wards coming to their ward at night to heat up food or go to other wards. The provider took action to address this. Staff completed risk assessments for patients requesting visits from adults and children.

• There were some restrictive practices at the hospital. For instance on Danbury and Chelmer wards, informal patients did not have easy access to community leave. Staff locked the wards and had to escort patients to leave the building. Staff had displayed signage stating that patients should ask staff if they wanted to leave the ward. However, in informal patient's care records we saw in in care plans, the provider's 'conditions of admission' and welcome packs that patients needed to seek the 'permission' of the nurse in charge and consultant before leaving the hospital for any reason. This posed a risk that informal patients would not be aware of their rights to leave the hospital when they wanted.

• Staff's practice in managing medicines needed improvement. For instance, staff had not recorded they had given a Chelmer patient medication one day; the variable dose was not signed on a patient's medicine chart. On one occasion, staff gave a patient more medication than prescribed. Staff had not attached two Danbury patients' photographs to their medication prescription charts for staff to check when giving medication. Chelmer staff had not always recorded clinic room temperature checks.

• Staff had restricted patients on the addictions treatment programme's access to having family visits for seven days after admission. There were restrictions on patients' access to using information technology equipment, which staff

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

referred to as a 'digital detox'. However, staff said they told patients this before admission and staff said they considered individual patient's needs and could make exceptions to this.

• Staff told us they had policies and procedures for searching patients on return from leave. The provider had a missing person protocol for staff to follow in case patients did not return from community leave.

• Ward staff had achieved 100% compliance with safeguarding training. Staff said they had received safeguarding training and knew how to raise concerns and report issues and we observed an example of this.

• Staff completed drug tests with addiction patients to assess dependency and to inform detoxification plans.

• A pharmacist visited the hospital once per week to review and monitor prescription charts, medication ordering and storage of medication and fridge temperature. They completed a monthly audit, which managers reviewed in monthly clinical governance meetings. Managers had addressed an issue for a Springfield patient when medication was missing and other ward's staff had taken it. Staff used rapid tranquilisation following National Institute for Health and Care Excellence guidance.

Track record on safety

• As of November 2017, there were three serious incidents relating to Springfield and Chelmer wards. Two others related to the outpatients department and another area of the hospital.

Reporting incidents and learning from when things go wrong

• There were delays in staff reporting incidents as nursing assistants and agency staff did not have access to the provider's electronic system to log them. Instead nurses or ward managers had to log incidents for them. Danbury ward staff had delayed reporting two incidents on the electronic system, one of which was ten days before. Staff had not recorded another incident on the system and had not recorded it in the patient's notes. Staff said they would not have given verbal information about these incidents at the daily hospital wide information sharing 'flash' meetings either. This posed a risk that managers would not be informed about incidents and risks in the hospital in a timely way and take action to address the issues.

• Managers took limited action following incidents. Managers did not record how they shared lessons with staff. The hospital director acknowledged that improvements were required for incident reporting. For example, a manager had recorded learning from an incident as 'not applicable'. Staff had not recorded their rationale for restraining a patient or what rapid tranquilisation medication they gave. Staff had not detailed on an incident report how a patient had self-harmed. Staff had not recorded their holding techniques used in restraining a patient on another record. (We had raised this as an issue for CAMHS ward staff at our last inspection).

• Staff stated they did not specifically assess patients for risks when they were escorting patient to placements, which may be long distances away. This was despite a serious incident where a patient had absconded. Governance meeting minutes showed that staff had discussed incidents reported. Staff told us they knew how to report incidents.

• The provider had explained to patients when things had gone wrong, for example in complaints responses. However, Springfield patients said that staff had removed their curtain tiebacks and clothes hangers without giving reasons.

• Staff received feedback from incidents investigations by email through 'Safety and quality bulletins' and' learning of lessons' meetings. A manager said the provider had issued staff with keys to trigger fire alarms after a number of incidents where patients on CAMHS ward had set off alarms to try to abscond. Managers gave feedback to staff about the need to observe patients in the bathroom if on constant observations via the learning outcomes meeting.

• Staff had opportunities for debriefs after incidents.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

• We checked a sample of 20 care and treatment patients' records. Staff had assessed patients after admission.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

However, the quality varied across wards. For example, staff had not fully completed six patients' assessments across wards on the provider's standard template. It was unclear if staff had considered these issues. There was a delay and were gaps in three patients' records indicating staff had not started daily recording of the patients' presentation on the day of the patients' admission. Initial doctor's assessments on Chelmer ward were more detailed than Danbury ward.

• Doctors had completed a physical examination of patients and there was ongoing monitoring of patient's physical health problems. However, a patient on Springfield ward told us staff had not taken a blood test for a month, which they had raised with staff. Staff had not fully completed the physical health form for a Chelmer patient receiving treatment for addictions, nor was a urine analysis completed. There was no record of blood pressure monitoring for another patient.

• The provider had standard care plan headings 'keeping safe', 'healthy' and 'connected'. Patients had personalised, holistic, recovery-oriented care plans. However, two patients 'staying connected' care plans were not fully completed, which could pose a risk that staff would not know what support to give them to keep contact with family and friends and their community. One Chelmer patient's care plan was not holistic.

• Managers demonstrated they were monitoring care plans review dates in the 'flash' meeting. We heard staff discussing when care plans were due for updates on Danbury ward and.

• Staff kept patient care and treatment information in electronic and paper records systems. Ward staff had different systems to keep information such as mental capacity assessment forms and legal detention papers on Danbury ward were kept in paper files. Staff said bank and agency staff could access records.

Best practice in treatment and care

• Most staff were following National Institute for Health and Care Excellence guidance when prescribing medication. However, a doctor had prescribed two medications for a Danbury patient which was contrary to guidance as might affect their ability to perform skilled tasks

• Chelmer staff had not recorded if blood borne virus testing was offered to patients being treated for addictions and had not documented if they had a history of intravenous drug usage.

• The provider offered psychological therapies recommended by the National Institute for Health and Care Excellence. This included cognitive behavioural therapy, dialectical behavioural therapy, which patients could also access on discharge if treated in their outpatients and day hospital services as appropriate. There was less reference in care records that Danbury patients accessed these. Staff said they offered short-term programmes due to patients' usually having a short length of stay.

• Managers had recruited a registered general nurse to work on Chelmer ward and told us they were seeking to employ two more to lead on physical health issues across the other wards. Staff could refer to other specialist services such as dieticians. Staff offered weight reduction support to patients on Chelmer ward.

• Staff were assessing patients' nutrition and hydration needs on Springfield ward. The provider had a policy and protocol for staff to follow for nasogastric tube feeding patients. Patients with eating disorders were on diet plans in accordance with the provider policy and the 'Management of Really Sick Patients with Anorexia Nervosa' guidance (MARSIPAN) (Royal College of Psychiatrists, 2014). Staff used the MARSI modified early warning system tool when checking patients' physical health.

• Staff used recognised rating scales to assess and record severity and outcomes for example 'Health of the Nation Outcome Scales', the 'Generalised Anxiety Disorder assessment' tool for patients to self-rate and the 'patient health questionnaire 'tool for screening, diagnosing, monitoring and measuring the severity of depression. Staff used the 'Eating Disorder Examination Questionnaire' a self-report questionnaire with patients.

• Patients with addictions had psychological interventions and participated in the 12-step programme. However, staff were not measuring outcomes of the effectiveness of the treatment they gave patients.

• Clinical staff participated actively in clinical audit such as the 'preventing suicide a toolkit for mental health service external audit' 2017. The provider had developed an annual audit list.

Skilled staff to deliver care

• The team included registered mental health nurses and nursing assistants, consultants, doctors, occupational therapists, psychologists, counsellors and therapists. The provider had employed a social worker.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

• As of November 2017, staff were not receiving regular supervision for their role as per the provider's standard of 90%. Information received afterward showed 53% of staff supervision was late and this was evident from checking a sample of records. This posed a risk that supervisors were not regularly offering support to staff and were checking staff were carrying out their role appropriately. However, staff told us they had access to supervision. We checked sample of supervision records and saw that staff were able to raise issues with managers. Managers told us they addressed poor staff performance promptly and effectively. In one instance, records did not corroborate the information a manager had told us.

• As of November 2018, managers had completed 100% of appraisals with staff.

• Staff received an appropriate induction.

• Staff received training relevant to their role including eating disorder training and naso-gastric (NG) tube administration. The provider had ensured that staff received adequate training to treat patients with addictions following our last inspection. However, as of November 2017 Springfield and Danbury wards were below the provider's standard for 'confidentiality and data protection' training. Sixty percent of Springfield ward staff had completed the 'introduction to mental health' training. Danbury ward had the lowest compliance for the introduction to health and safety with 66% and moving and handling training, 44 %. Managers told us that whilst they had systems to check agency staff's training on starting, they did not have a procedure for reviewing this and check their training was up to date.

Multi-disciplinary and inter-agency team work

• Managers held regular and effective multi-disciplinary 'flash' meetings to give staff updates on issues in the hospital.

• Staff reported effective handovers within the team (e.g. shift to shift).

• Staff said they had effective working relationships including good handovers with other teams in the organisation. We observed this in multi-disciplinary meetings and through staff, giving verbal updates to staff coming onto the ward. However, three staff reported communication challenges with Springfield ward staff.

• The provider worked with external agencies including local authorities, the GP, and local authority safeguarding teams.

• The provider followed the framework of the care programme approach (CPA). Staff invited community teams to attend hospital-based meetings and to maintain contact and involvement with patients. We heard staff contacting teams outside of the organisation such as community mental health staff. Several staff said there were difficulties with community staff attending meetings as some patients were over 50 miles away from their home area.

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

• There were systems for staff to examine patients' detention papers on admission. The provider had appointed a MHA administrator and had an identified lead manager who they could contact with queries. The provider had a central team giving support to the hospital.

• Staff kept records of section 17 leave granted to patients.

• As of January 2018, 92% of staff on these wards had training in the Mental Health Act. The provider had not identified this as a mandatory training subject for all staff.

• Danbury ward staff had an incident where an assessment for a patient under the Mental Health Act 1983/2007 had not taken place, despite an initial request nine days before. Staff had not raised their concerns with hospital managers for their support to resolve the matter. Staff did not have a clear management plan for how to support the patient in the interim and were not clear about their legal responsibilities. We requested further information from the provider about this.

• Staff had attached copies of consent to treatment forms to medication charts where applicable. The provider carried out audits to check that staff were gaining patients' consent regarding their care and treatment.

• Staff explained patients legal rights under the MHA on admission and routinely thereafter.

• Patients had access to an independent mental health advocacy service that visited wards.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Good practice in applying the Mental Capacity Act 2005

• As of January 2018, 92% of staff across these wards had training in the Act. The provider had not identified this as a mandatory training subject for all staff.

• No patients were subject to a Deprivation of Liberty Safeguards (DoLS) application during our visit. The provider had a policy on the Mental Capacity Act including DoLS, which staff could refer to. Staff knew where to get advice within the hospital.

• Staff discussed patients' capacity to make specific decisions at multi-disciplinary reviews and we saw examples of this in records. Danbury ward had separate forms that staff completed with patients. Staff said they gave patients assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it.

• Staff said that they would not ask patients receiving treatment for addiction to sign treatment contacts whilst intoxicated.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

• Twelve of thirteen patients told us that staff were caring, treated them with dignity and respect and gave them support, which helped them in their recovery. We confirmed this through our observations.

• Staff had an understanding of patient's individual needs.

• A patient and a carer stated that staff communication with them about care and treatment issues needed improvement.

The involvement of people in the care they receive

• The admission process informed and oriented the patient to the ward and the service. Information booklets were available to help and orientate patients to the ward and the service. This included a 'conditions of admission' form, which outlined expectations, for example, on arrival; privacy and behaviour that staff asked patients to sign on admission.

• Staff involved patients in their care and treatment for example through gaining their views in multi-disciplinary meetings (ward rounds) and mutual help meetings. Staff offered patients copies of their care plans and referenced their view about their care. However, two of twenty records held limited information. Advance decisions were not in place stating how patients would like staff to treat them if their mental health deteriorated.

• Care records showed that staff were contacting patient's carers (as relevant) to gain their views. Staff said they gave opportunities for carers to attend meetings, which a carer confirmed.

• Patients had access to advocacy services.

• Patients were able to give feedback on the service they receive. For example, 'your say forums' had taken place twice in 2017. Each of the wards had community meetings. The senior management team had bi monthly meetings with Springfield ward patients.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Requires improvement

Access and discharge

• Springfield ward had the highest average bed occupancy from June to November 201, with 99%. The Lodge had 85% occupancy. Danbury ward and Chelmer ward had the lowest occupancy with 78% and 72% below the average (85%) recommended for adult in-patient mental healthcare.

• Patients had access to a bed on return from leave. Danbury and Chelmer ward told us that they could get more than one patient admission in a day.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

• Springfield ward also had the highest length of stay for patients with 166 days, the lodge had 26 days, Chelmer ward had 18 days and Danbury was the lowest with 14 days.

• Springfield had the longest waiting times due to the severity of the patients admitted and their length of stay. The provider stated they reviewed their waiting list and commissioners often had placed patients elsewhere.

• The provider received referrals from NHS and privately funded patients. Staff had a screening tool to assist them in managing referrals. The provider's staff screened referrals from a central team and they would then send to the hospital for staff to screen and decide on admission. Staff discussed admissions and discharges of patients at morning 'flash' meetings. Some staff said there was pressure from the provider not to decline patients for admission and they were now admitting patients with more complex needs.

• Care pathways and admissions could be from secure units, prison, courts or other inpatient units. Commissioners referred patients from various parts of the country due to placements not being available in their home area or the local trust to meet their needs. This meant that commissioners funding NHS patients on Chelmer and Danbury could refer or request patients' discharge at short notice. Some patients were more than 50 miles from their home.

• There were no delayed discharges of patients between January to October 2017. We found one example where a patient was waiting for their local community mental health services to identify appropriate accommodation to go to in the community. Three patient's records on Springfield and Danbury wards did not have information about discharge planning

• Staff had ensured that most patients' care plans held discharge plans, such as staff liaising with their commissioners and community teams to assist them back to their local community. The hospital social worker said they helped patients maintain links with their local area teams. We observed that staff discussed discharge plans with patients at multi-disciplinary team meetings. Staff checked that patients with addictions had sponsors and liaised with their GPs on discharge. Staff signposted patients to external services and arranged for patient's appointments at their outpatients and day hospital service as appropriate.

The facilities promote recovery, comfort, dignity and confidentiality

• The wards had rooms and equipment to support treatment and care. For example, Danbury had a therapies and meeting room. Springfield had an activities room. Patients could access the day hospital services as appropriate.

• Patients were able to telephone others in private, unless there were specific risks or they had signed a contract as part of their treatment for addictions. However, Springfield ward's payphone was in a public area.

• Danbury ward had rooms identified for visitors. Springfield and Chelmer patients could have visitors on the ward or could use the multi faith room.

• Patients had access to garden areas. Springfield patients has less easy access and had to ask staff to let them have access.

• Several patients were complimentary about the food. Chelmer and Springfield patients used a dining room off the wards for meals and shared a communal and female lounge. Springfield patients had access to a room to eat snacks. Patients had access to drinks and snacks.

Patients could personalise their rooms. Springfield patients had also displayed inspirational quotes to encourage patients with their recovery. Danbury ward ensuite washrooms had pictures on the doors.

• Patients had access to safes to store their possessions in although one patient said it took some time to get the access code. Patients did not have keys to their rooms due to the locking system. This could affect patient's privacy, dignity and safety.

• There was not privacy screening on Danbury's downstairs bedroom windows. This meant others could look into their rooms from the garden.

• Danbury ward staff held a stock of spare clothing for patients in case they had limited possessions on admission.

• Staff had developed ward group timetables, which were not individualised for patients. For example on Springfield,

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

groups were available such as goal setting, tai chi or yoga and nutritional body image. Nursing staff and an occupational therapist provided activities at weekends. As part of the safe wards scheme, staff and patients had developed, a 'mutual help meeting' on Danbury ward. However, five patients said there should be more treatment and activities offered to them.

Meeting the needs of all people who use the service

• Springfield ward was on the ground floor so patients with mobility difficulties could access the ward and garden. Female patients on Danbury and Chelmer wards had access to a lift (on Danbury).

• The provider had an accessible information policy. Information leaflets were available on request in different languages if required. Staff had access to interpreters, when needed, to aid communication with patients whose first language was not English or signers.

• Information on patients' rights, treatment, how to complain, advocacy and safeguarding were available for patients

• Patients had choices of food to meet religious and cultural dietary requirements.

• The provider offered a chaplaincy service to support patients to access spiritual support whilst in hospital. The hospital's multi-faith room was not fit for the purpose of contemplation or prayer as staff often used it for other purposes.

• We saw examples in care records where staff had recorded patients' ethnicity or sexuality. However, staff had not detailed how staff should best support a patient regarding their needs. Staff told us of the actions they would take to address this. Another patient had raised concerns about staff lack of support for their diverse needs and we saw that staff had investigated their concerns. Staff explained how they had met transgender patients' needs.

• The provider offered a range of detoxification services including for alcohol and opiate use. However, The Lodge residential rehabilitation service for patients receiving treatment for addictions was not fully open. This meant that patients who had finished detoxification on Chelmer ward did not move to the rehabilitation service.

Listening to and learning from concerns and complaints

• The hospital had received seven complaints for Chelmer and Springfield wards from April to December 2017, most of which related to therapy, of which the provider had partially upheld four.

• We checked a sample and saw that investigations had taken place and staff gave patients feedback on the outcome.

• The provider had received 19 compliments about its service, Chelmer had the highest with 10 and Danbury had none.

• Staff reminded patients on how to raise a complaint in community meetings. There were posters on the wards and information in patient information booklets. Wards had suggestion boxes for patients and others to give their feedback on services. The provider stated they would try to resolve issues locally where possible.

• Therapy service staff invited patients to give feedback on the services through a satisfaction survey. The provider had carried out a survey with Chelmer and Springfield ward patients in 2017 and had developed action plans for issues identified.

• Staff received feedback on the outcome of investigation of complaints at team meetings.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Vision and values

• Staff had an understanding of the organisation's values. The organisation linked its purpose and behaviours to staff appraisals and to the new care certificate workbooks for staff.

• Staff knew who the most senior managers in the organisation were.

Good governance

• The provider's governance systems were not fully effective in monitoring the service provided. Two issues highlighted at our previous inspection had not been addressed:

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

ligature risk assessment and management and how staff managed male visitors on Chelmer ward. Managers had identified the need to improve Chelmer and Springfield ward environments, they had gained costings but there were not clear timescales and action plans for making all of these improvements.

• Staff had delayed in reporting some incidents and managers were not fully reviewing those reported to check the quality and identify risks and areas for improvements. Managers stated this was an area for improvement.

• There were risks relating to the managers oversight of staff, which could affect patient care. Managers had not ensured that all staff were receiving supervision as per their standard. Their recruitment processes were not fully effective as there were several nursing staff vacancies, which managers said was a challenge. Wards used a notable level of agency staff that were not regular and managers were not regularly reviewing their training.

• Staff discussed a range of issues and risks at their 'flash' meetings, senior management and clinical governance committee meetings. Meeting minutes did not always details timeframes and actions.

• Managers had arranged for staff to transfer to Danbury ward when it opened to enhance the staffing team and ensure the team had some staff with the provider's systems.

• The provider used key performance indicators to gauge the performance of the team.

• Staff had the ability to submit items to the provider's trust risk register. Ward managers had sufficient authority and administrative support.

• The managers had a system for auditing the service for example relating to the pharmacy.

• Managers had oversight of staff training and had improved staff's compliance with this.

• The specialist doctor for their addictions treatment programme had shared learning with staff, relating to changes to prescribing from the 'Drug misuse and dependence: UK guidelines on clinical management' often referred to as the 'orange book'. However, they had not fully developed their within the service yet.

Leadership, morale and staff engagement

• Most staff reported effective team working, support and good morale.

• Staff know how to use whistle-blowing process. They said they felt able to raise concerns without fear of victimisation.

• The provider gave staff opportunities to give their feedback on services and input into service development, such as 'your say' forums.

• Springfield and Danbury ward managers had started in post in 2017 having worked in other areas.

• The provider had developed a workforce race equality standard statement. They employed 24% of staff from a black or minority ethnic background; 30% were in clinical work with 36% employed as band four staff, nursing assistants.

• The provider's staff survey April 2017 identified that staff's overall satisfaction was 63% less than the provider's overall results (77%). Strengths included enjoyment of role and training and improvements included confidence that the provider would take action to address issues and workload. The provider had developed a response for staff.

Commitment to quality improvement and innovation

• The provider completed 'quality walk rounds' by senior staff, patients and staff to record the quality of the hospital.

• Staff, patients and carers were able to nominate staff members for awards where the provider recognised staff for their contributions to the service.

• Springfield ward had received accreditation for the Quality network for eating disorders. Hospital accreditation assures staff, patients and carers, commissioners and regulators of the quality of the service provided.

• Other provider sites had adopted the hospital's addictions therapy programme training following staff presentations. Staff had shared information about the work of the team via the provider's blog with others in the organisation.

Requires improvement

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

• The provider had taken some actions to ensure ligature risk assessments identified ligature points. We found staff did not have access to all information about ligature risk assessments to manage the risks. For example, the telephone in a lounge and window blinds in the education room were not clearly identified on the ligature risk assessment. Staff said the telephone room was kept locked. Staff did not have a copy of the external area ligature assessments. The provider took action to address this during our visit.

• Wards had ligature points, for example, window and washroom fittings. A ligature point is anything, which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff told us that shower curtains were changed to be collapsible at a weight of 20 kg. The television in the main lounge was securely boxed in but had to be left open, as young people could not hear it. Staff had not fixed a bedroom mirror securely to the wall.

• The quality network report 2017 stated that the provider should consider whether more 'safe rooms' were needed on the ward. The provider had identified the need to improve bedrooms identified for young people with higher dependency needs and the ward environment. They had sourced options for reducing ligature risks, replacing windows and fitting anti barricade doors to make the ward similar to Danbury ward. However, there were no clear timescales and action plans for all of these changes.

• The ward layout had blind spots where staff could not easily observe young people. The location the ward office did not enable staff to observe all parts of the ward. However, staff managed this with CCTV and staff observations of patients.

• There was no specific de-escalation space for staff to use when young people were distressed or agitated. This was identified in the (QNIC) Quality Network for Inpatient Child and adolescent mental health service (CAMHS), Royal College of Psychiatrist's peer review 2017. Staff said they could use alternative areas such as; the person's bedroom, the quiet room, the main lounge, they could close off the downstairs corridor, or use an area upstairs. However, this could disrupt other young people. The width of corridor and use of stairs could present challenges. The quiet room was not a low stimulus area. Instead, it was set up more as an activities or meeting room with formal tables, chairs and art materials. This could affect the safety of staff and patients.

• The ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that staff checked regularly.

• Maintenance staff had decorated communal areas due to recent damage by young people. Maintenance staff were still making repairs to furnishings when we visited. Some bedroom walls had holes filled and were not yet painted. One bedroom had a boarded window-awaiting repair. Ward areas were clean.

• The provider had some systems completing environmental risk assessments. The provider and regular fire safety checks and fire drills took place. However, the fire blanket was missing in the kitchen. Staff had access to appropriate alarms and nurse call systems were available in every room.

• The Department of Health guidance on same-sex accommodation for children and adolescents, differs from adults in that it states young people should be given the choice as to if they go to a mixed sex ward or not. All young people's bedrooms had ensuite washrooms and male bedrooms were grouped near the staff office with most female bedrooms upstairs. The provider had ensured young people had access to a single sex lounge. Most patients were female when we visited.

• Ward areas were clean. Staff adhered to infection control principles including handwashing. Cleaning staff had checklists for their role and the environment was regularly cleaned. Three young people expressed concerns about the ward environment, for example about cleanliness. The provider had systems for ensuring other equipment was maintained.

Safe staffing

• The nursing staff establishment for the ward was eight whole time nurses and 22 nursing assistants. The provider had estimated the number and grade of nurses required for each shift. The staff to patient ratio was 1:4, with a requirement for at least three nurses, three nursing assistants on duty in the day, two nurses, and three nursing assistants on duty at night. The provider had stated that there should not be more than three agency staff to be used each shift. The quality network report stated that this does not meet the current staffing standards set by them.

• There were three nurse and one nursing assistant vacancies for the ward. The ward manager said the staff sickness rate from December 2016 to November 2017 was 5-6%. This is above the average for NHS trusts (4.2%). There were six staff leavers (three nurses and three nursing assistants) over the last year.

• The quality network report 2017 had commented on the overuse of agency staff on the ward. In January 2018, agency staff covered 214 nursing staff shifts and bank staff covered 87. Staff told us that bank (employed by the provider on an as and when basis) and agency staff were used to cover vacancies. Managers said they did not 'block book' staff for a specific period for wards. Staff from September 2017 to January 2018 did not cover sixteen shifts. Two staff said staffing levels were insufficient.

• Managers reviewed staffing daily in 'flash' meetings and staff could request additional staffing if the level of young people's acuity was such that additional staff were required.

• Staff said staffing levels did not affect them from safely carrying out physical interventions with patients. Young people said they did not regularly have easy access to fresh air in the garden due to staffing.

• There was a designated consultant and specialist doctor for the ward. The provider had arranged for regular agency doctors to be on site out of hours. In a medical emergency staff would call '999 for an emergency service response.

• As of January 2018, over 80% of staff had completed mandatory training.

Assessing and managing risk to young people and staff

• We checked six records and staff had completed the provider's risk assessment tool for every young person on admission and had updated them regularly.

• Staff told us that they were now admitting young people with greater acuity and dependency needs and higher risk levels since our last visit. However, during our visit the ward had a calmer atmosphere than on the previous visit.

• One young person had been in long-term segregation and staff had not placed anyone in seclusion during June to November 2017.

• The ward had the highest amount of restraints with 38 incidents reported for 16 young people, June to November 2017. Of these staff had reported five incidents of restraint in prone position but stated they it was not to give rapid tranquilisation. The provider stated that they do not support the use of prone restraint. On the few occasions staff used it they had addressed it directly with the staff involved and a team incident review was completed. Staff told us that they would not usually restrain young people in prone position for this and gave an example of placing young people in kneeling position. We noted one incident form had an error as to whether or not staff had used prone restraint.

Requires improvement

Child and adolescent mental health wards

• The provider had taken action since our last visit to ensure that staff recorded the holds they used when restraining young people. The quality network report 2017 had stated that the service should also consider increasing the amount of restraint training that staff received. Staff compliance rate for prevention and management of violence and aggression training was 90% above the provider's standard and 71% of staff had completed 'managing challenging behaviour training' just below.

• The hospital had an identified safeguarding lead. Ninety eight percent of staff had training in safeguarding and staff knew how to raise concerns and report issues.

• The ward had some restrictions as it was locked and young people needed to ask staff to let them off the ward if they wanted to leave. Young people could not easily access the downstairs garden as staff kept the stairwell locked, as there were ligature risks. Young people were reliant on staff being available to escort them to the area. Staff kept the main lounge door locked in the day to encourage young people to go to education classes.

• Staff told us they had policies and procedures for observation of young people and searching them on return from leave. The provider had a 'missing person' protocol for staff to follow in case young people did not return from community leave.

• The provider had an identified room off the ward for visits although visits generally took place in patient's bedrooms.

• We did not identify any concerns relating to the management of medicines on this ward. Staff used rapid tranquilisation following National Institute for Health and Care Excellence guidance. The provider had arranged for a pharmacist to visit the hospital once per week to review and monitor prescription charts, medication ordering and storage of medication and fridge temperature. They completed a monthly audit, which managers reviewed in monthly clinical governance meetings.

Track record on safety

• There were were six serious incidents for this ward December 2016 to November 2017. These related to absconsion, aggression, self-harm and safeguarding. CAMHS wards had notably more serious incidents and restraints than the adult wards. The provider confirmed that the CAMHS ward had the highest ratio of incidents with self-harm the highest type.

Reporting incidents and learning from when things go wrong

• There were delays in staff reporting incidents as nursing assistants and agency staff did not have access to the provider's electronic system to log them. Instead nurses or ward managers had to log incidents for them. From a sample of eight incident reports, there were gaps in seven records with limited learning and actions taken by managers on review of incidents. Three records did not describe the incident, including in one instance if staff had used de-escalation techniques. One record stated that a young person was supported to their room and did not detail if staff had restrained them or not. Two records did not detail what medication staff had given to the young person. The hospital director acknowledged that improvements were required for incident reporting.

• Governance meeting minutes showed that staff had discussed incidents reported. Staff told us they knew how to report incidents.

• We found examples of the provider explaining to patients when things had gone wrong.

• Staff said they received feedback from incidents investigations by email through 'Safety and quality bulletins'. Staff said the provider had removed curtain pelmets following an incident when a young person self harmed tying a ligature to a curtain pelmet that did not collapse. Staff told us that the curtain rails were magnetic, collapsible and anti ligature. Staff told us that they were given belts to hold their keys after an incident where a young person took staff's keys to abscond from the ward.

• Most staff told us they had opportunities for debriefs after incidents. However, two said these did not always take place.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

• We checked a sample of six young people's care and treatment records.

• Staff had assessed patients' needs after admission.

Requires improvement

Child and adolescent mental health wards

• Five care records showed that doctors had completed a physical examination of young people and there was ongoing monitoring of their physical health problems. However, we could not find a record for one young person.

• The provider had standard care plan headings 'keeping safe', 'healthy' and 'connected'. Young people had personalised, holistic, recovery-oriented care plans.

• Managers demonstrated they were monitoring care plans review dates in the 'flash' meeting.

• Staff kept patient care and treatment information in electronic and paper records systems.

Best practice in treatment and care

• Staff were following National Institute for Health and Care Excellence guidance when prescribing medication.

• The provider could offer psychological therapies recommended by the National Institute for Health and Care Excellence guidance such as family therapy and mindfulness.

• The provider told us they were seeking to employ a registered nurse to lead on physical health issues. Staff could refer to other specialist services such as dieticians.

• Staff were assessing patients' nutrition and hydration needs.

Staff used recognised rating scales to assess and record severity and outcomes for example 'Health of the nation outcome scales for children and adolescents' and assessment tools such as the 'Autism diagnostic observation schedule' is a semi-structured assessment for individuals suspected of having autism or other pervasive developmental disorders.

• Clinical staff participated actively in clinical audit. The provider had developed an annual audit list.

Skilled staff to deliver care

• As of November 2017 staff were not receiving regular supervision for their role as per the provider's standard of 90%. This ward was the lowest with 40% compliance. January 2018 information showed 53% of staff supervision across the hospital was late. This posed a risk that supervisors were not regularly offering support to staff and were checking staff were carrying out their role appropriately. However, a manager said they were developing a clinical supervision group for staff. Staff told us they had access to supervision.

• Managers had completed 80% of appraisals with staff, as of November 2017.

• The team included registered mental health nurses and nursing assistants, consultants, doctors, occupational therapists, psychologists, counsellors and therapists. The provider had employed a social worker.

• Staff received an appropriate induction. A manager said that 30% of staff had previous experience of working with children and adolescents with mental health difficulties, before working on the ward. Staff received training relevant to their role including training from the psychologist. Seventy three percent of staff were trained in the provider's 'working with young people' training. Nursing assistant staff had training on 'therapeutic interventions and approach'. As of November 2017, the lowest staff compliance with training was 'confidentiality and data protection' training with 57% compliance; 'understanding your role' training with 53% compliance and 'the 'introduction to mental health' training with and introduction to mental health training with 46%. Managers told us that whilst they had systems to check agency staff's training on starting, they did not have a procedure for reviewing this and check their skills were being maintained.

Multi-disciplinary and inter-agency team work

• The provider had regular and effective multi-disciplinary 'flash' meetings to give staff updates on issues for the hospital.

• Staff had handovers within the team (e.g. shift to shift). Staff said they had effective working relationships including good handovers with other teams in the organisation. We observed this in a multi-disciplinary meeting.

• The provider worked with external agencies including local authorities, the GP, and local authority safeguarding teams.

• The provider followed the framework of the Care Programme Approach (CPA). Community teams were encouraged to attend hospital-based meetings and to maintain contact and involvement with the young people.

• Several staff said there were difficulties with community staff attending meetings as some young people were over 50 miles away from their home area.

Requires improvement

Child and adolescent mental health wards

Adherence to the Mental Health Act 1983/2007 and the MHA Code of Practice

• The provider had a system for identified staff to examine young peoples' detention papers on admission. The provider had appointed a MHA administrator and had an identified lead manager who they could contact with queries. The provider had a central team giving support to the hospital.

• Staff kept records of section 17 leave granted to young people.

• As of January 2018, 86% of staff across the hospital had training in the Mental Health Act. The provider had not identified this as a mandatory training subject for all staff.

• Staff had attached copies of consent to treatment forms to medication charts where applicable. The provider carried out audits to check that the legal authority for admission and treatment was clear if a young person was detained under the MHA.

• The provider had systems for ensuring staff explained young people's legal rights under the MHA explained to them on admission and routinely thereafter.

• Young people had access to an independent mental health advocacy service that visited wards.

Good practice in applying the Mental Capacity Act 2005

• The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over who are unable to make all or some decisions for themselves.

• As of January 2018, 90% of staff had training in the Mental Capacity Act. The provider had not identified this as a mandatory training subject for all staff.

• Staff discussed young peoples' consent and capacity to make specific decisions at multi-disciplinary reviews and we saw examples of this in four records. However, two young people's records held limited information.

• Staff referred to and completed 'Gillick' competence for young people. Staff need to assess if children under 16 years have enough understanding to make up their own mind about the benefits and risks of treatment – this is termed 'Gillick competence'. Eighty-two percent of staff who work with young people also had training regarding the 'Fraser' guidelines.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

• Four young people told us that staff were caring, treated them with dignity and respect and gave them support, which helped them in their recovery. We confirmed this through our observations.

• Staff referred to having specialist training and working with young people in accordance with five principles 'nurture, expectations, respect, enabling and reflection'. They had small prompt cards as a reminder of the principles.

• Staff had an understanding of young people's individual needs.

• Three young people and two carers stated that staff could improve communication with them about care and treatment issues.

The involvement of people in the care they receive

• The provider had taken actions following our last inspection to offer young people copies of their care plans. One young person referred to staff using 'Getting to know me' documentation to help them know their likes and dislikes. However, two young people said staff only asked them to sign their care plan just before the CQC visit; one person said they had not been involved in the development.

• Staff involved young people in their care and treatment for example through gaining their views multi-disciplinary meetings (ward rounds).

• The provider had information booklets available to help and orientate young people to the ward and the service.

• Young people confirmed they had access to advocacy services.

• Carers said that staff were contacting them to gain their views. Staff said they gave opportunities for carers to attend meetings, which carers confirmed. Managers told us that the therapist run carers group was short listed for an organisational 'Pride Award' for recognising good practice .

Requires improvement

Child and adolescent mental health wards

• Young people were able to give feedback on the service they receive. For example, 'your say forums' had taken place twice in 2017. Each of the wards had community meetings. The senior management team had bi monthly meetings with young people, so that they can raise any issues directly. A young person told us they were involved in recruiting new staff.

Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Requires improvement

Access and discharge

• The average bed occupancy over the last six months was 86%, similar to the national average. Young people had access to a bed on return from leave.

• The average length of stay for young people was 54 days, which is less than the national average of 116 days identified by NHS England 2013.

• The provider received referrals from NHS and privately funded young people. The provider had a screening tool to assist them in managing referrals. Managers told us that the provider's staff screened referrals from a central office and then they would send to the hospital for staff to screen and decide on admission. Staff discussed admissions and discharges of young people at morning 'flash' meetings. However, we received conflicting information from staff as to who made the decision to admit young people to the ward. Some staff said there was pressure from the provider not to decline the admission of young people, if beds were available. Staff told us there had been difficulties and delays in transferring young people to a more suitable environment, when they needed a higher level of care; such as a high dependency unit or psychiatric intensive care unit.

• Care pathways and admissions could be from community services or other in young people units. Young people were placed from various parts of the country due to placements not being available in their home area or the local trust to meet their needs.

• Staff said that they held an initial planning meeting with carers and community teams seven days after the young person's admission and a care programme approach meeting, six weeks after admission. Staff arranged telephone conference facilities if people had difficulty attending the unit. The provider stated there were no delayed discharges of young people between January to October 2017 and none were identified at our visit.

• The hospital social worker said they helped young people maintain links with their local area teams. However, five young people's records did not have information about discharge planning arrangements.

The facilities promote recovery, comfort, dignity and confidentiality

• The wards had some rooms and equipment to support treatment and care. For example, there was an education room. However, a peer review report June 2017, by the quality network report had stated that the service should reflect on whether or not the number of beds was suitable for space on the unit.

• The ward has 17 beds this was above the national average for a CAMHS ward. The provider had not specifically designed the ward to meet the needs of young people. It was on the second and third floor and access to the garden was on the ground floor. Four staff raised concerns about the environment and if it was appropriate for young people. The garden space was now smaller to reduce risk of young people absconding. However, a larger garden area was available for those patients who had been assessed as lower risk of absconding. Managers informed us that they had plans to refurbish the ward and move the education room. Although they did not give a specified timeframe for completion.

• One bedroom did not have curtains to reduce the risk of young people self-harming. It did not have privacy screening on the window. Staff said they would supervise a young person in the ensuite bathroom. Staff were unable to tell us what alternative options they had considered to manage a young person's dignity and privacy.

• Young people still congregated in the main corridor area near the ward office. There was a quiet room but staff and patients said they often used it for meetings and therapy.

• Young people could personalise their rooms. Staff had ensured that young people had to safes to store their possessions in, following our last inspection; although they did not have the access code. They did not have keys to their rooms.

Requires improvement

Child and adolescent mental health wards

• Young people were able to telephone others in private, unless there were specific risks. They could have visits from family or friends on the ward or in identified rooms off the ward as appropriate.

• Young people could access the internet access in education room. Young people had access to drinks and snacks. Staff had developed ward group timetables, which were not individualised for young people. However, one young person said there should be more treatment and activities offered to them.

Meeting the needs of all people who use the service

• The ward was not easily accessible by a young person or visitor with physical mobility difficulties.

• Information on young peoples' rights, treatment, how to complain, advocacy and safeguarding was available for young people.

• The provider had an accessible information policy. Staff had access to interpreters, when needed, to aid communication with young people whose first language was not English or signers. Information leaflets were available on request in different languages if required.

• Young people had choices of food to meet religious and cultural dietary requirements. Although a young person said, there were limited vegetarian choices.

• The provider offered a chaplaincy service to support young people to access spiritual support whilst in hospital. The hospital's multi-faith room was not fit for the purpose of contemplation or prayer as staff often used it for other purposes.

• The Office for Standards in Education, Children's Services and Skills (OFSTED) inspected the education department in March 2017 and rated the service as 'outstanding'.

Listening to and learning from concerns and complaints

• The ward had received 19 compliments, the highest amount in the hospital.

• The provider had five complaints for the ward from April to December 2017, which related to communication and management of risk. The provider had partially upheld all of these. We checked a sample and saw that investigations had taken place and staff gave young people or carers feedback on the outcome.

• Staff reminded young people on how to raise a complaint in community meetings. There were posters on the wards and information in information booklets. Wards had suggestion boxes for young people and others to give their feedback on services. The provider stated they would try to resolve issues locally where possible.

• Therapy service staff invited young people to give feedback on the services through a satisfaction survey.

Are child and adolescent mental health wards well-led?

Requires improvement

Vision and values

• Staff had an understanding of the organisation's values. The organisation purpose and behaviours were linked to staff appraisals and into the new care certificate workbooks for staff.

• Staff knew who the most senior managers in the organisation were.

Good governance

• We identified some areas of risks that the provider was not fully addressing in the hospital that could affect patients' care, which we have reported on. For instance, the provider had not fully addressed an issue relating to ligature assessment and management as we still found risks. The provider had taken some actions since our last inspection

• The provider had not ensured their service was in line with the quality network guidance for CAMHS wards. Managers had identified the need to improve the ward environment, were gaining costings but there were not clear timescales for making all of these improvements.

• Managers were not fully reviewing those incidents reported to check the quality and identify risks and areas for improvements. Managers had identified this as a challenge.

• There were risks relating to the managers oversight of staff, which could affect patient care. The provider had not ensured that all staff were receiving training and supervision as per their standard. Their recruitment processes were not fully effective as there were several

nursing staff vacancies, which managers said was one of their challenges. This ward used a notable level of agency staff that were not regular and managers were not regularly reviewing their training.

• Staff discussed a range of issues and risks at their 'flash' meetings, senior management and clinical governance committee meetings. Meeting minutes did not always details timeframes and actions.

• The provider used key performance indicators to gauge the performance of the team.

• Staff had the ability to submit items to the provider's trust risk register.

• The managers had a system for auditing the service for example relating to the pharmacy.

Leadership, morale and staff engagement

• Most staff reported effective team working, support and good morale.

• The ward manager had started in 2017 and had an opportunity for leadership management training.

• The provider's staff survey April 2017 identified that staff's overall satisfaction was 63% less than the provider's overall results (77%). Strengths included enjoyment of role and training and improvements included confidence that the provider would take action to address issues and workload. The provider had developed a response for staff.

• Staff knew how to use whistle-blowing processes. They said they felt able to raise concerns without fear of victimisation.

• Staff were offered opportunities to give feedback on services and input into service development, such as 'your say' forums.

• The provider had developed a workforce race equality standard statement. They employed 24% of staff from a black or minority ethnic background; 30% were employed in clinical work with 36% employed as band four staff, nursing assistants.

Commitment to quality improvement and innovation

• The provider completed 'quality walk rounds' by senior staff, patients and staff to record the quality of the hospital.

• Staff, patients and carers were able to nominate staff members for awards where staff were recognised for their contributions to the service.

• The ward was a member of the Quality network for inpatient child and adolescent mental health service (CAMHS) wards who had completed a peer review of their service in 2017.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

• The provider must ensure that staff complete initial assessments for patients.

• The provider must ensure that staff offer blood borne virus testing for patients being treated for addictions.

• The provider must ensure staff complete and record observations of patients.

• The provider must ensure that all patients have personal emergency evacuation plans.

• The provider must ensure staff follow medicines management procedures correctly.

• The provider must fully comply with the Department of Health and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex accommodation across all wards.

• The provider must ensure that Danbury ward downstairs bedroom windows have privacy screening.

• The provider must review their ligature assessment and management processes.

• The provider must ensure that male visitors are not left unsupervised in female areas on Chelmer ward.

• The provider must ensure all incidents are reported, detailed and reviewed to identify any actions to take to prevent a reoccurrence.

• The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff are working on wards.

• The provider must ensure all staff receive supervision as per the provider's standard.

• The provider must review their provision on the CAMHS ward to ensure it meets quality standards.

• The provider must review their governance systems for assessing and monitoring the quality and safety of the hospital.

• The provider must ensure there are clear plans and timescales for the improvements of ward environments.

Action the provider SHOULD take to improve

• The provider should ensure that all patients' risks are updated in their records.

• The provider should ensure that informal patients are aware of their right to have community leave.

• The provider should ensure that staff are aware of the legal responsibilities in respect of the Mental Health Act 1983/2007 1983.

• The provider should review Danbury wards external fencing to ensure it is safe.

• The provider should ensure that patients' records contain discharge plans.

• The provider should review their plans for the closure of The Lodge.

• The provider should ensure that CAMHS staff complete the introduction to mental health training.

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 The provider had not complied with the Department of Health and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex accommodation across all wards. The provider had not ensured that Danbury ward downstairs bedroom windows had privacy screening. This is a breach of regulation 10(1)(2)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not ensured that staff completed initial assessments for patients. • The provider had not ensured that staff completed and recorded observations of patients. • The provider had not ensured that staff offered blood borne virus testing for patients being treated for addictions. • The provider had not ensured that all patients had personal emergency evacuation plans. • The provider had not ensured that staff were following medicines management procedures correctly. • The provider did not have robust their ligature assessment and management processes. • The provider had not ensured that male visitors were supervised in designated female areas on Chelmer ward.

This section is primarily information for the provider

Requirement notices

• The provider had not ensured that all incidents are reported and reviewed to identify any actions that can be taken to prevent a reoccurrence.

This is a breach of regulation 12 (1) (2) (a)(b)(c)(d)(e)(g).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not ensured provision on the CAMHS ward to ensure it meets national standards. • The provider had not ensured effective governance systems for assessing and monitoring the quality and safety of the hospital. • The provider had not ensured that there were clear plans and timescales for the improvements of ward environments. This is a breach of regulation 17(1)(2) (a)(b)(f).

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 • The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were working on wards. • The provider had not ensured that all staff received supervision as per the provider's standard. This is a breach of regulation 18(1) (2)(a)