Active Young People Limited

Taplow Manor

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

Taplow Manor is a specialist child and adolescent mental health inpatient service (CAMHS). It provides specialist mental health services for adolescents and young people from 12 to 18 years of age.

Our rating of this location went down. This inspection rated Taplow Manor as inadequate and placed them into special measures.

We rated it as inadequate because:

- Tamar ward remained unfit for purpose. This had been a concern in the last 3 inspections. The provider had developed a feasibility study and were submitting a planning application so a new purpose built ward could replace it. However, there had been little progress to mitigate the immediate concerns about the ward environment and it was not well maintained.
- Tamar ward was unclean. Floors and carpets were heavily stained and there was dirt throughout the ward. Bathroom areas and the clinic room were unclean.
- Not all of the wards at the hospital were well maintained. Ward furniture was in a state of disrepair, there was graffiti on the walls and peeling paint.
- Staff training compliance with immediate life support training was still low.
- Physical health observations after the use of rapid tranquilisation were not always being undertaken.
- The recording of nasogastric tube insertion and administration of feed lacked detail and was not in line with guidance.
- Treatment programmes and activities for young people across the hospital were starting to improve. However, this work required further embedding across the hospital.
- Care plans did not demonstrate that children and young people had been involved in their development and represented their voice and views. There was little evidence that young people had been offered a copy of their care plans.
- Supervision rates for staff across the hospital were variable.
- We saw evidence the hospital had better oversight of governance processes and were progressing with the site improvement plan. However, some of the improvements were still in their infancy and further work was required to embed and sustain changes. There were also concerns found during the inspection which the hospital's governance processes had not identified or mitigated against.

However:

- Vacancy rates were reducing, and the provider was actively recruiting international staff.
- Observation procedures had significantly improved across the hospital. Staff were trained in observations and processes were in place to establish competency with the observation policy.
- Staff understood how to safeguard patients and were compliant with safeguarding training.
- The investigation of incidents had improved since the last inspection. Incidents were investigated thoroughly and staff were provided with a debrief. The hospital learned lessons from incidents and shared these.
- Positive Behaviour Support plans were in place for all young people. Young people had been involved in their development and staff had received training.
- Managers used audits to make improvements. The hospital had recently implemented a new audit schedule across the hospital.

Summary of findings

- Staff treated young people with kindness and respect. Staff supported young people and involved their families or carers.
- Young people and their relatives and carers knew how to complain or raise concerns.
- Staff morale was improving and the senior management team had implemented a number of initiatives to improve engagement with staff and improve well-being and morale.
- Leaders at the hospital had shown a commitment to making the improvements required following the last inspection. A site wide improvement plan was in place to measure progress and the actions required.

What people who use the service say

We received mixed feedback from young people across the hospital.

Young people said staff treated them with respect and dignity and ensured that their needs were met.

They were sometimes bored outside of school hours or if not in school as there were no other activity programmes during this time. Mobile phones and television programmes on streaming services were not available during school hours, even if they were not at school.

Young people told us they weren't always involved in their care plans or received copies of their care plan.

Some young people said that the food was good, while others said it could be better.

Young people on Kennet ward said new staff or staff who cover from other wards as well as agency staff will sometimes say and do inappropriate things as they don't understand eating disorders.

Some young people said it could take time for staff to respond to requests when the wards were busy.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inadequate 	Our rating of this service went down. We rated it as inadequate. See summary above for details.

Summary of findings

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Summary of this inspection

Background to Taplow Manor

Taplow Manor is a specialist child and adolescent mental health inpatient service (CAMHS). It provides specialist mental health services for adolescents and young people from 12 to 18 years of age. The hospital delivers specialised clinical care for young people requiring inpatient CAMHS, including psychiatric intensive care (PICU) and eating disorders. The hospital and its surrounding grounds are within a rural setting and are situated near a town with easy access to transport links and shops. Young people are supported in their education via the hospital school which is rated good by Ofsted. Where appropriate the young people have access to the hospital grounds and local community facilities.

When all the wards are fully open, the hospital has 59 beds. The PICU wards have a cap on admissions and are only able to admit a maximum of 22 young people due to conditions imposed on its registration by CQC at a previous inspection in July 2021. At the time of this inspection, the cap was still in place.

The hospital consists of five wards:

- Kennet ward provides eating disorder services and has 20 beds
- Tamar ward provides tier four CAMHS general adolescent services and has 10 beds
- Juniper ward provides PICU services and has 7 beds
- Holly ward provides PICU services and has 8 beds
- Maple ward provides PICU services and has 7 beds.

There was a registered manager in post at the time of the inspection.

The hospital is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures.

Following the previous inspection in July 2022, we issued a letter of intent under section 31 of the Health and Social Care Act 2008. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. A letter of intent sets out our intention to take urgent action if the provider does not assure us that it will make the required improvements urgently. The provider submitted an action plan to us and assured us they were taking immediate actions to improve the safety of the hospital. As such we did not take further action at that time. As a result of the July 2022 inspection we rated the hospital as requires improvement overall, with a rating of inadequate in the safe domain, requires improvement in the effective, caring and well led domain and good in the responsive domain.

Following the inspection in July 2022 we issued the provider with requirement notices. We told the provider to make the following improvements:

- The service must ensure that all relevant staff are appropriately trained and assessed as competent to carry out observation checks of young people. (Regulation 12)
- The service must ensure that all ward environments are fit for purpose. (Regulation 15: Premises and equipment, (1)(c) and (e))

Summary of this inspection

- The service must ensure that staff receive a debrief and/or reflective practice session following serious incident, including after incidents that involve restraints. (Regulation 12)
- The service must ensure that staff have completed managing medications and immediate life support training. (Regulation 12)
- The service must ensure that young people and the relevant family/carers are involved in care and treatment planning. (Regulation 9)
- The service must ensure that young people have access to the recommended psychological therapy as outlined in best practice guidance and that young people have access to meaningful activities seven days a week. (Regulation 9)
- The service must ensure that there are effective and robust governance procedures in place to ensure that young people always receive safe care and treatment. (Regulation 17)
- The service must ensure that they complete the actions of the action plan following the issue of the letter of intent and embed the improvements to the service. (Regulation 17)

During this inspection we saw that the provider had made improvements in the areas of concerns we had found in July 2022, but had not met all of the requirement notices. We also found new concerns during this inspection relating to governance, the cleanliness of Tamar ward, maintenance issues on Tamar and Kennet wards, the physical observations of young people following the use of rapid tranquilisation and the recording of nasogastric tube insertion and administration of feed lacked detail.

The hospital had improved the process around observations of young people. There was now a daily checklist in place to ensure staff on shift were trained and competent to undertake observations of young people. There were also processes in place to ensure young people's observations were undertaken as prescribed. The hospital was monitoring observations through regular audits and a standard operating procedure had been implemented to ensure all staff followed the Supportive Engagement and Observation Policy and were competent to use it.

Training compliance rates among staff had improved for managing medications. However, the training rate for Immediate Life Support training was still low. Staff requiring this training had dates booked to complete it by January 2023.

We found some of the ward environments were still unfit for purpose. A feasibility study had been developed and planning permission was being sought to replace Tamar ward with a purpose built ward. Refurbishment of the psychiatric intensive care units had now been completed.

The hospital recognised there were still actions that needed to be completed and work was required to embed the improvements to ensure they would be sustained permanently. The provider had introduced a new governance system and developed a comprehensive site improvement plan to monitor progress against each of the actions contained within it and had detailed oversite of progress.

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?

Summary of this inspection

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The team that inspected this service comprised of three CQC mental health inspectors, one CQC inspection manager, the National Professional Advisor for Children and Adolescent Mental Health service, one specialist advisor, and one expert by experience. The expert by experience has lived experience of mental health services. The specialist advisor has professional experience of working in child and adolescent mental health services.

Before the inspection visit, we reviewed information that we held about the service and met with stakeholder organisations.

During the inspection visit, the inspection team:

• Undertook a tour of the hospital and all wards

• Spoke with 15 children and young people who were using the service

• Spoke with 7 relatives/carers of children and young people who were using the service

• Spoke with the hospital director who is the registered manager for the service

• Spoke with 27 staff members including ward managers, health care assistants, nurses, consultant psychiatrists, occupational therapists, dietitians and members of the senior management team.

• Looked at eight care and treatment records • Reviewed 16 medication charts • Attended and observed one site operations meeting and

• Reviewed a range of policies, procedures and other documents relating to the running of the hospital.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure all areas of the hospital premises, including clinic rooms are kept clean (Regulation 15: Premises and equipment (1)(a))

Summary of this inspection

- The provider must ensure that all ward environments are fit for purpose and properly maintained. (Regulation 15: Premises and equipment (1)(c) and (e))
- The provider must ensure that staff have completed immediate life support training (Regulation 12)
- The provider must ensure young people receive physical health observations following the use of rapid tranquilisation in accordance with national guidance and the providers policy. (Regulation 12)
- The provider must ensure that young people are involved in care and treatment planning. (Regulation 9)
- The provider must ensure that they continue to complete the actions of the site wide improvement plan following the issue of the letter of intent and continue to progress in embedding improvements to the hospital. (Regulation 17)
- The provider must ensure the documentation of nasogastric feeding is recorded in line with national guidance. (Regulation 17)
- The provider must ensure governance processes in place assess, monitor and improve the quality and safety of the service provided and assess monitor and mitigate the risks relating to the health safety and welfare of service users and others who may be at risk. (Regulation 17)

Action the service SHOULD take to improve:

- The provider should ensure all staff receive regular supervision.
- The provider should ensure all young peoples' personal preferences are identified and followed.
- The provider should ensure that they fully embed ongoing work around young people having access to meaningful activities and recommended therapies as outlined in best practice guidance
- The provider should ensure all patients have discharge planning detailed in their care records.
- The provider should ensure young people have access to independent interpreters as required.
- The service should review the shared bedroom arrangements in Kennett ward.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inadequate	Requires Improvement	Requires Improvement	Good	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Good	Inadequate	Inadequate

Inadequate

Child and adolescent mental health wards

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Good
Well-led	Inadequate

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Not all ward environments were suitable to meet the needs of young people. Tamar ward was visibly unclean. Two of the wards required maintenance and refurbishment. However, the refurbishment of the psychiatric intensive care wards had been completed.

Safety of the ward layout

Tamar ward remained unfit for purpose. At the previous two inspections of the hospital we had been told a planning application was due to be submitted to seek permission to replace the current ward with a purpose-built general adolescent ward. The application was in the process of being submitted following the completion of a feasibility study.

Tamar ward was an old building with narrow corridors. The ward was split across different levels which made it difficult for staff to observe all parts of the ward. The ward had CCTV to assist with observations.

The layout of Kennet ward continued to be problematic. The ward was divided over different levels and involved going up and down small sets of stairs to access the different areas of the ward. For example, the bedroom areas were up a small set of stairs, to access the lounge area involved going up and down stairs across a landing area. This increased the risk of trips and falls. Kennet ward is a specialist eating disorder ward and the layout could be challenging for individuals in poor physical health. Kennet ward had blind spots. The ward had CCTV which was monitored by an external company who would contact the hospital if required.

Juniper ward was a 7-bed mixed-gender child and adolescent (CAMHS) psychiatric intensive care unit (PICU). Holly ward was an 8-bed mixed-gender CAMHS PICU. Maple ward was a 7-bed mixed CAMHS PICU. At the time of the last inspection Juniper ward was under refurbishment having been split from a larger ward into two smaller PICUs. Holly ward was closed during the last inspection and was under construction. This was the first time we had inspected the two wards in their new configuration following the refurbishment.

Inadequate

Child and adolescent mental health wards

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Each ward shift had a member of staff allocated to complete a daily security checklist and completed walk throughs of the wards to check and assess for risks.

Tamar, Holly and Juniper wards accepted young people of any gender. Kennet ward only accepted females. The wards that accommodated young people of different genders complied with guidance on mixed sex accommodation.

There were potential ligature anchor points throughout the hospital. Staff were aware of potential ligature anchor points and ligature audits were completed on all the wards. The risks associated with ligature points were mitigated by staff supervision in certain areas, CCTV and observations. Areas with ligature points were locked while not in use. Each of the wards had a ligature heat map displayed in the nursing stations. This identified areas where ligature points were present. During our previous inspection we highlighted that staff undertaking observations were not competent to do so. This had improved significantly since the last inspection and all staff were trained in undertaking observations. This was reviewed every shift by the nurse in charge.

Staff had easy access to alarms and children and young people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Tamar ward was unclean throughout. Carpets were heavily stained, there was loose debris and dirt throughout the ward on the floors. There was a heavy accumulation of cobwebs in the clinic room on the ward. We also observed dried spillages on the flooring and radiators in the dining room. The walls were marked with graffiti in some areas and walls had peeling paint. There was dust and dead flies on the windowsills in most areas. The bathroom areas were unclean with dirty sinks and overflowing bins.

Tamar ward was not well maintained. Some of the ward furniture was in a state of disrepair and had ripped fabric. An internal door which required repair was being propped open with an old shoe. We were told this was because the door banged and needed maintenance. We were given assurances the cleanliness was to be addressed and more regular quality walk arounds by senior staff were due to commence following the inspection.

Kennet ward required redecoration. There was graffiti present on the walls, some of which was of a sexual nature. There was also graffiti on some of the bedroom furnishings. The lounge area was due for refurbishment and new furnishings were on order. However, at the time of the visit the lounge did not offer sufficient seating for all the young people on the ward. Some of the furnishings throughout the ward had significant damage. For example, furniture in young people's bedrooms required replacement, there was an armchair in the lounge that had all the foam missing from one arm and there were also bean bags that were flat from extensive use.

Staff followed infection control policy, including handwashing. There were hand sanitising stations throughout the hospital. Staff were wearing face masks throughout the hospital.

Seclusion room

The hospitals only seclusion room was located on Juniper ward. The seclusion room had the toilet, shower and sink located within the seclusion room and not in en-suite arrangement. Young people in seclusion were required to sleep, eat and be in the same room as the toilet. This meant that young people using these facilities would have to sleep, eat

and be in the same room as the toilet which may compromise their dignity. Young people in seclusion could maintain their privacy when toileting and were able to have shutters closed on the windows. Due to the shower being located in the seclusion room this posed a potential risk of slips and falls to the young person in seclusion but also any staff required to enter the seclusion room when the floor was wet. The seclusion room had access to outside space.

Clinic room and equipment

The standard of cleanliness and the equipment available in the clinic rooms varied across the wards. The clinic room on Tamar ward was very small, had a significant amount of dust and cobwebs hanging from the ceiling and had no examination couch.

The clinic room on Kennet ward was in need of decoration and the window restrictor in the room was broken which meant the window could be completely opened.

The clinic room on Juniper ward was very small and lacked space. Physical health observations were undertaken in a separate examination room

The clinic room on Holly ward was large and contained an examination couch.

With the exception of Tamar ward, the clinic rooms were clean. Staff completed weekly clinic room audits and an external pharmacist completed monthly audits. The rooms had accessible resuscitation equipment and emergency drugs were checked regularly.

Safe staffing

Whilst the service had enough staff, who knew the children and young people, there was still a high use of agency staff. Not all staff had immediate life support training.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe.

The service had reducing vacancy rates.The hospital was actively recruiting nursing staff internationally. This had helped improve the vacancy rates for permanent nursing staff. The hospital were due to onboard 15 new nurses in January 2023. The hospital was also using a 'grow your own nurses' initiative and support workers had recently qualified as nurses using this scheme.

The service had reducing rates of bank and agency nurses. Managers requested agency staff familiar with the service and block booked staff to assist with consistency. All agency staff had an induction to the hospital and wards and understood the service before starting their shift. Staff were required to undertake a two-week induction and the completion of 4 shadow shifts before starting to take shifts. However, some young people told us engagement with

Managers supported staff who needed time off for ill health.

Levels of sickness were low.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Each ward calculated the staffing establishment based on acuity and the level of observations required. Holly ward and Juniper ward both had 3 qualified nurses who worked across the wards. Holly ward had 9 healthcare assistants and Juniper ward had 13 healthcare assistants. Tamar ward had two qualified nurses on shift and between 5 and 6 healthcare assistants dependent on need. Maple had two qualified nurses on shift and between 5 and 6 healthcare assistants dependent on need

Ward managers could adjust staffing levels according to the needs of the children and young people. There was a daily site operations meeting where staff were allocated to wards based on acuity levels, for example enhanced observations of young people.

Children and young people sometimes had their escorted leave, or activities postponed. When this happened young people were offered their escorted leave as soon as possible after the postponement.

The service had enough staff on each shift to carry out any physical interventions safely. Kennet ward had extra staff on shift due to the level of physical interventions to support nasogastric tube feeding under restraint.

Staff shared key information to keep children and young people safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was an out of hours on call rota so a doctor was always available for support. There was CAMHS and eating disorder consultant psychiatrist cover on each of the wards and an associate specialist doctor and physical health doctor to lead on all physical health concerns.

Mandatory training

Staff had completed and kept up-to-date with the majority of mandatory training. However, immediate life support training compliance was 32%. We saw evidence the 16 staff members who required the training were booked onto training courses at the end of December 2022 and the beginning of January 2023.

During our last inspection we found not all staff had completed supportive observation and engagement training nor completed and passed the supportive observation and engagement competency assessment. During the last inspection there were high numbers of permanent and agency staff being allocated observation duty whilst on shift without the necessary training or competence. We found during this inspection the hospital had significantly improved practice around observation training and competency. A daily nurse in charge checklist had been introduced to ensure all staff on shift were trained, competent and that observations of young people had been carried out as prescribed. There were also audits in place to monitor compliance with observations. A standard operating procedure had also been introduced which sought confirmation that all staff on shift were competent and supervised against the Supportive Engagement and Observation Policy. The hospital had also introduced a new on-boarding system for agency staff members. This process included checks against mandatory training compliance, including observation competence. Agency staff who had not passed all the required mandatory training were unable to book onto shifts until all training had been completed.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Inadequate

Child and adolescent mental health wards

Managers monitored mandatory training and alerted staff when they needed to update their training. Monthly reports were presented to the clinical governance meeting regarding compliance with mandatory training. Reports on training compliance were issued by the hospital director to heads of department for follow up. The hospitals electronic recording system produced reminders to managers when staff training was due to expire and required refreshing. The people co-ordinator emailed any staff member with an overall training compliance of between 65-84% to ensure action was taken.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, young people were not routinely monitored post rapid tranquilisation for their physical health observations.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, children and young people.

Staff followed procedures to minimise risks where they could not easily observe children and young people. The hospital used a remotely observed CCTV system. Areas of the wards were under constant observation if there were heightened risks. The remote provider would contact the hospital if they observed safety concerns. The hospital could also request footage to use in the review of incidents. The hospital received reports from the remote observation provider that highlighted good or concerning issues within the hospital which were used to influence staff learning. The hospital also had their own CCTV system which was viewable in each of the nursing stations and was live streamed.

Staff followed the providers policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. The hospital had conducted feeds under restraint. Such incidents were reported on the hospitals incident management system and care plans were in place.

Staff were able to give examples of strategies used to try and de-escalate situations.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The hospital had issued guides and tools around the restraint reduction network standards to staff and were revising their policy around this.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

We reviewed four records where rapid tranquilisation had been used on Holly ward. In three of the records the young person had only been followed up for physical health observations for the first hour afterwards and none thereafter. In the fourth record no physical health observations were recorded and the young person was only noted to be sleeping.

When a child or young person was placed in seclusion, staff kept clear records and followed best practice guidelines.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff had received training in Level one, Level two and Level 3 safeguarding children as required in line with the intercollegiate document requirements..

Staff kept up-to-date with their safeguarding training. Staff compliance with safeguarding training was monitored and refreshed as appropriate.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff had good links with local agencies relating to safeguarding.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The social work team acted as the safeguarding link for advice and support across the hospital.

The hospital had a daily site meeting where the tracking of safeguarding incidents and concerns and the associated actions were monitored. The service had regular meetings with the local authority, commissioners and other stakeholders to review open safeguarding cases.

Some of the wards had posters relating to safeguarding on the walls which had out of date information. We raised this with the hospital who immediately replaced these with the up to date information.

Staff access to essential information

Inadequate

Child and adolescent mental health wards

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

The hospital's electronic records system was experiencing a prolonged outage following a national cyber-attack which had impacted on providers across the country. Patient notes were comprehensive but they were being stored on shared drives and in paper based records. This made it difficult to triangulate all information as different disciplines were storing records in their own shared folders. However, staff we spoke to could give detailed information about each young person and the care required. Each of the wards discussed patients in the shift handover meetings.

Records were stored securely within the hospital.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The hospital had a weekly audit completed by an external pharmacist and any actions identified for taken forward by managers.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were all electronically prescribed and held through the external pharmacy. There were weekly medicines stock audits to ensure medicines did not run out.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Inadequate

Child and adolescent mental health wards

Staff knew what incidents to report and how to report them. Staff used the hospital's electronic incident system to report incidents. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff reported serious incidents clearly and in line with policy. The service had not had any never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. At our last inspection we found there was inconsistencies in the investigation of incidents relating to observations of young people. Practice had significantly improved since the last inspection. Following any observation related incidents the competency around the policy would be addressed with staff and further training would be put in place if required. For example, an incident had occurred where a patient who was on 1:1 observations attempted to ligature. The hospital investigated using the CCTV and saw the young person had been left alone for 15 seconds. Staff had acted quickly and intervened. The staff member who was undertaking the observation was required to recomplete the observation competency and there was evidence the staff member had received additional support about how to deal with distractions when they were undertaking observations of young people.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. The hospital had implemented a safety review tracker which was used following incidents. The review group met to review an incident and detailed the outcomes and further actions to be taken.

There was evidence that changes had been made as a result of feedback.

Managers shared learning with their staff about never events that happened elsewhere. The hospital circulated a lessons learned bulletin via email to all nurses who were required to print the bulletin off so all staff could review the content and learning. Staff were then required to sign to confirm they had read the bulletin.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. However, care plans were not always personalised, holistic and recovery-orientated.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after.

Inadequate

Child and adolescent mental health wards

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. Care plans were reviewed and updated when children and young people's needs changed. However, care plans reviewed did not have a strong representation of the children and young person's voice and views. Care plans had not been signed by the young people and there was no indication the young people had been offered a copy of their care plan. We observed a patient review meeting where the team were taking account of young people's views and preferences, however, this did not translate into the documented care plans.

We reviewed care plans associated with feeding young people under restraint. While care plans were in place, the plans contained minimal detail on supportive approaches pre feed, during feed and post feed. The recording of nasogastric tube insertion and administration of feed also lacked detail when measured against the recommended seven-point quality of documentation to record a minimum dataset which was devised following the National Patient Safety Alert for nasogastric feeding in 2011. There was no record of the length the tube was inserted to, no record of which nostril the tube was inserted into and no record of clinical assessment of the nasal cavity, as recommended in the seven-point quality of documentation dataset. There was no indication the practice guidance had not been followed and there were no incidents of misplacement, however, the recording lacked sufficient detail and evidence of all the interventions undertaken.

Young people all had Positive Behaviour Support (PBS) plans in place. An allocated support worker on each of the wards updated these plans with young people regularly. Staff had received training on PBS to implement a new system and develop plans across the hospital. Young people we spoke to described how they had been involved in the development of their PBS plan.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The hospital had implemented a number of new treatment programmes since the last inspection. These included the Carousel programme which was a rolling group treatment designed for young people to increase their range of coping strategies. Facilitators used cognitive behavioural and personal construct psycho-therapy techniques. The So Maybe I'm Like Everyone else (SMILE) project was aimed at helping young people gain insight into their diagnosis. There were also a number of new groups including healthy relationships and DBT skills. We saw some positive psychological groups being held on the PICUs. Activity co-ordinators were in place to ensure that activity timetables were being developed and spanned 7 days per week. There were four youth engagement practitioners and activity coordinators in post who worked outside of school hours including evenings and weekends to facilitate activities. However, the work around treatment programmes and activities hospital wide was still in its infancy and required further embedding. For example some of the groups were yet to be rolled out on the General Adolescent Unit and needed adapting for the eating disorder ward.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg NICE).

Staff identified children and young people's physical health needs and recorded them in their care plans.

Inadequate

Child and adolescent mental health wards

Staff made sure children and young people had access to physical health care, including specialists as required.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. The hospital used the Hospital Anxiety Depression Questionnaire (HDAS) and the Coping Skills Questionnaire to measure outcomes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements. There was an audit schedule which had recently been implemented across the hospital. These audits included care plans, clinical governance, hand hygiene, medicines management, mattress and safeguarding

Skilled staff to deliver care

The ward teams' access to the specialists required to meet the needs of children and young people on the wards was improving. Managers made sure they had staff with the range of skills needed to provide high quality care.

The service had improved the numbers of specialists required to meet the needs of children and young people since the last inspection. There was still a shortage of dieticians and occupational therapists and recruitment was ongoing

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including agency staff. Agency staff could no longer take on shifts at the hospital if they had not completed the required training specified by the hospital.

Managers gave each new member of staff a full induction to the service before they started work. New staff were required to undertake a two week induction and four shadow shifts before they could work on the wards.

Supervision rates for staff were variable across the hospital. Most staff we spoke with said they were not receiving regular supervision from their manager. The overall compliance for supervision at the hospital was 77%; Kennet ward (70%), Tamar ward (75%), Juniper (50%), Holly (55%), Maple (90%).

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The wards held team meetings and made minutes available to those who could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers received regular reports about staff training compliance and ensured staff completed and could access training when required.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers provided examples where they had recognised and dealt with poor performance.

Inadequate

Child and adolescent mental health wards

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. All members of the young persons team attended meetings and contributed their views, this included nurses, healthcare assistants, dieticians, occupational therapists, psychologists and the consultant psychiatrist. We were told by staff these meetings were inclusive and everyone could contribute to the discussions.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. Handover meetings were held on each of the wards at the beginning and end of each shift. Information about each young person was discussed.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The staff training compliance for Mental Health Act training was 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrator were and when to ask them for support. The hospital now had a permanent Mental Health Act Administrator in post.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. We were told advocates attended the hospital 3 times per week and attended each of the wards on a weekly basis. The hospital referred patients to an advocate but there were sometimes long waits due to staffing issues within the advocacy provider.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Leave was sometimes cancelled at short notice but young people were facilitated to take their leave as quickly as possible thereafter.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Inadequate

Child and adolescent mental health wards

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

Is the service caring?

Requires Improvement

Our rating of caring stayed the same. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity.

Staff were discreet, respectful, and responsive when caring for children and young people. We observed positive interactions between staff and young people during the inspection.

Staff gave children and young people help, emotional support and advice when they needed it.

Staff supported children and young people to understand and manage their own care treatment or condition.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Children and young people said staff treated them well and behaved kindly.

On Tamar ward we reviewed a care plan of a young person who identified as male. However, in the care plan interchangeable pronouns were used and the young person was referred to as both “he” and “she”.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff did not always involve children, young people and their families in care planning.

Involvement of children and young people

Staff did not always involve children and young people or give them access to their care plans and risk assessments. Young people we spoke to had not had sight of their care plans or signed them. Since our last inspection the hospital

and re-issued the policy and process for the MDT to involve and document that a young person and their family or carer (where appropriate) had been involved in their care plan development. Compliance checks had begun in the ward round and MDT meetings to ensure this was completed, however this process was still being embedded and young people were not always involved in their care plans.

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties).

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Each of the wards held regular community meetings where young people could provide feedback on the service.

Staff made sure children and young people could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Parents were given a single named point of contact who they could liaise with for updates. The named contact was identified in MDT meetings who were responsible for communication with family and carers. This work was being embedded at the time of the inspection and an audit was being reported to the matron and medical director. Families and carers were also provided with a slot they could dial into for the weekly ward rounds.

Staff helped families to give feedback on the service. The hospital has recently had a family day on Kennet ward where family had the opportunity to provide feedback on the service.

Parents were sent a monthly newsletter with updates about the hospital.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

In most instances staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

The hospital had a maximum capacity of 52 young people at the time of the inspection. When young people went on leave there was always a bed available upon their return.

Managers regularly reviewed the length of stay for young people. They worked with relevant organisations when young people had long lengths of stay. The hospital also engaged with local community teams via the care co-ordinators after CPA discharge and planned any additional input that was required.

The hospital had out of area placements due to the specialist nature of the hospital and the national shortage of beds for children and young people with mental health conditions. The hospital was the only location with PICUs in the wider geographical area. The hospital had close links with the local provider collaborative who commission some beds at the hospital. The hospital also had links with out of area placements local provider collaboratives.

Children and young people were moved between wards during their stay only when there were clear clinical reasons or it was in their best interest. We saw an example of a transfer from one ward to another where a "getting to know me" document was prepared in collaboration with the young person. It was written by the young person due to anxiety about moving wards. The document stated a number of topics and how to support them, for example meal time support, distraction techniques and interests and dislikes.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

Staff did not move or discharge children and young people at night or very early in the morning.

Discharge and transfers of care

The hospital had a number of delayed discharges in the previous year. Managers monitored delayed discharges and had regular strategy meetings with local authorities to assist with discharge arrangements. The reason for the delayed discharges were due to young people waiting for suitable placements and accommodation to be found.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. However, in 2 records we reviewed we found that the records had a lack of discharge planning detailed. Parents we spoke to told us the hospital could improve on the way discharge is planned.

Staff supported children and young people when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The furnishings of the wards supported children and young people's treatment, privacy and dignity. Except for Kennet ward, which had shared bedrooms, each child and young person had their own bedroom. Not all bedrooms were en-suite. There were lockers on the wards to keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people could make hot drinks and snacks at any time.

Tamar, Juniper, Maple and Holly ward each had individual bedrooms for young people which could be personalised. This included blackboards on the walls for young people to express themselves and write messages to staff about likes and dislikes. We saw young people had personalised their bedrooms with personal possessions such as toys and teddy bears.

Kennet ward had six bedrooms which were double rooms and were shared by two young people at a time.

Children and young people had a secure place to store personal possessions.

Inadequate

Child and adolescent mental health wards

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where children and young people could meet with visitors in private.

Children and young people could make phone calls in private.

The service had an outside space that children and young people could access easily. All four PICU wards had access to the same garden space. This was a large space with astroturf, goal posts for football and benches. The other wards also had access to outside space with benches.

Children and young people could make their own hot drinks and snacks and were not dependent on staff.

Some young people said the quality of the food was variable and they would like more choices.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education. The hospital had an onsite school which young people were encouraged to attend.

Staff helped children and young people to stay in contact with families and carers. Young people had communication care plans in place.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. The hospital took young people on trips outside of the hospital, for example the young people had recently had a trip to go ice skating and the cinema.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for those with communication needs or other specific needs. The hospital was not suitable for young people with a mobility issue.

Staff made sure children and young people could access age appropriate information on treatment, local services, their rights and how to complain.

The service had information leaflets available in languages spoken by children, young people and the local community.

We observed during a ward round that a young person whose first language was not English did not have an independent interpreter. A staff member who was fluent in the young person's first language provided translation. The hospital were experiencing difficulties sourcing external interpreters.

Inadequate

Child and adolescent mental health wards

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. The hospital catered for young people who may require halal, kosher and vegan food choices for example. The hospital had an inhouse catering team who attended community meetings for feedback on catering choices and any individual requests were dealt with by the catering team.

Children and young people had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. The complaints procedure was explained to young people during community meetings.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

While improvements were beginning to be demonstrated across the hospital in most areas, the plan still required further embedding to sustain improvements. Other areas of concern had also developed while the focus had been on actions from the last inspection. Progress with the environmental concerns on Tamar ward was slow and little mitigation had been taken to make improvements while the hospital awaited planning permission. The leadership had not identified or addressed new concerns which were found during this inspection.

However, following our last inspection the leaders of the hospital submitted an action plan to address the concerns raised. The leaders had shown an ongoing commitment and understanding of the measures required to make

improvements. The leaders of the hospital had developed a site wide improvement plan which was an overarching document which measured progress and actions required to make the required improvements at the hospital. This incorporated the required actions from the last inspection and also results of more recent internal audits. Progress was being made and monitored regularly.

Leaders had the skills, knowledge and experience to perform their roles. They were visible in the service and approachable for children, young people, families and staff. The senior management team were conducting regular quality walk arounds of the wards and also visited wards out of hours to visit night staff. However, these measures had not identified concerns such as cleanliness and maintenance issues.

The hospital had made a number of recent appointments in the leadership team whose impact was beginning to influence the required improvements.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. Staff we spoke to were positive about recent improvements and how it would benefit the hospital going forward.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff commented positively on the culture of the hospital. The leadership team had implemented a number of initiatives with staff to improve morale and engagement with staff. For example there were regular 'tea with senior management team' sessions on each of the wards and a staff breakfast club.

Governance

Our findings from the other key questions demonstrated that governance processes were improving but required further work to sustain the hospital's improvement trajectory following the previous inspection. However, governance processes had not identified new concerns that were identified during the inspection.

We could see the hospital had begun to make progress against the actions from the last inspection in July 2022. The site wide improvement plan was detailed, thorough and measurable. It was under regular review with individual action owners and there were regular meetings to discuss progress. The oversight and governance of the site improvement plan was robust. We noted that the observations of young people (which was a concern at the last inspection) had improved and a new process had been developed and was being followed. While the site improvement plan was in place and work was being undertaken against it, some of the improvements were still in their infancy and further work was required to embed and sustain changes. However, other concerns arose during this inspection, most notably cleanliness, maintenance, the monitoring of physical health observations following the use of rapid tranquilisation, the documentation of nasogastric feeding and involvement in care plans. Governance processes should have identified and addressed these concerns.

The hospital had implemented a newly refreshed clinical governance structure and all sub-groups within the structure had begun to meet regularly.

Inadequate

Child and adolescent mental health wards

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The hospital had introduced a new daily site operations meeting to keep an oversight of risk and actions needed to address them. The meetings had improved the allocation of staff to wards with the most acuity. While the hospital had made progress against the requirement notices from the last inspection, a number of the actions required further work to achieve the improvements fully. Other areas of concern had developed since the last inspection which the hospital's risk management processes had not identified.

Information management

Staff engaged actively in local and national quality improvement activities.

The hospital had been affected by a national issue where their electronic records system had experienced a security breach and prolonged outage. The records system was unavailable for staff to use at the time of the inspection. Staff had developed alternative ways of recording information on shared drives but in some instances these were compartmentalised by different disciplines. However, care records were available and up to date. The service was working with the care records provider to resolve the issue.

There was an audit programme in place and systems to review the findings and action outcomes.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Senior leaders had taken steps to improve communication with staff at the hospital since the last inspection and staff we spoke with said that they considered the senior team approachable. Managers engaged actively with other local health and social care providers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure that staff have completed immediate life support training (Regulation 12) • The provider must ensure young people receive physical health observations following the use of rapid tranquilisation in accordance with national guidance and the providers policy. (Regulation 12).

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 9 HSCA (RA) Regulations 2014 Person-centred care • The provider must ensure that young people are involved in care and treatment planning. (Regulation 9)

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 must ensure that they continue to complete the actions of the site wide improvement plan following the issue of the letter of intent and continue to progress in embedding improvements to the hospital. (Regulation 17) • The provider must ensure the documentation of nasogastric feeding is recorded in line with national guidance. (Regulation 17) • The provider must ensure governance processes in place assess, monitor and improve the quality and

This section is primarily information for the provider

Requirement notices

safety of the service provided and assess monitor and mitigate the risks relating to the health safety and welfare of service users and others who may be at risk. (Regulation 17)

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 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider must ensure all areas of the hospital premises, including clinic rooms are kept clean (Regulation 15: Premises and equipment (1)(a)) • The provider must ensure that all ward environments are fit for purpose and properly maintained. (Regulation 15: Premises and equipment (1)(c) and (e))