

Requires improvement

Coventry and Warwickshire Partnership NHS Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RYGHQ	Caludon Centre	Westwood, Spencer, Sherbourne, Beechwood, Hearsall	CV2 2TE
RYG79	St Michael's Hospital	Rowans, Larches, Willowvale	CV34 5QW

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Good



Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

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

Summary of findings

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Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as **requires improvement** because:

- Although the trust had begun work on removing potential ligature points there were still a large number of ligature risks in acute wards. Although there were risk assessment and management plans in place for these, wards were not always effectively adhering to them.
- The seclusion room was not safe. The narrow entrance to the doorway put staff and patients at risk of injury.
- Current compliance levels in Mental Health Act training were low.
- Bed occupancy rates of over 100% meant that wards regularly requested that patients had 'sleepovers' in other wards in order to accommodate new admissions. We were concerned that this practice could adversely affect patient well-being and increase risk.

However:

- The provider had installed many anti-ligature fittings to the psychiatric intensive care units (PICU), particularly Sherbourne. Staff mitigated any outstanding risks through good risk assessment and management practices.
- Wards and clinic rooms on wards were clean, well-ordered with equipment that was checked regularly. Staff monitored medication storage and administration. PICU wards were exceptionally clean and well-ordered.

- Staffing was sufficient to meet safe staffing levels. Wards were able to deploy additional staff to meet patient need, such as when observation levels required extra staffing. The wards used bank staff who were familiar with the ward.
- There were sufficient staff to carry out physical interventions. Doctors were available to respond to medical needs. The wards adhered to National Institute of Clinical Excellence (NICE) guidelines in prescribing medicines, including rapid tranquilisation. Staff reported incidents and there was evidence of learning from them. Debriefings and learning groups for staff took place led by relevant clinicians.
- With the exception of Mental Health Act training, staff were able to access required and specialist training.
- Risk assessments were in place and regularly updated. Restrictions on the wards were proportionate to the safety of the patients. We saw these were risk based and supported patient well-being. The service recorded and monitored seclusion appropriately.
- Care records were up to date and contained relevant information to assist in a patient's recovery. Mental Health Act documentation was good. Staff were trained in the Mental Capacity Act and applied then recorded issues of capacity and consent appropriately.
- The service consulted and involved patients and carers in patient care and treatment. Staff interacted with patients in positive respectful ways. We had positive feedback from patients and carers, particularly on the PICU wards. Patients felt they were listened to, could raise concerns and had ready access to advocacy services

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as requires improvement because:

- There were ligature risks on the acute wards. Although there were risk assessment and management plans in place for these, staff did not always adhere to these.
- Access to the seclusion room was not safe. The narrow entrance to the doorway put staff and patients at risk of injury.

However,

- PICU wards, particularly Sherbourne, had suitable anti-ligature fittings in place, and risk assessment and management effectively mitigated any outstanding risks.
- Clinic rooms on wards were clean, well-ordered with equipment that was checked regularly medication storage and administration was monitored effectively.
- Wards were clean and well-furnished. PICU wards were exceptionally clean and well-ordered.
- Staff carried personal alarms and were able to respond promptly to calls.
- Staffing was sufficient to meet safe staffing levels. Additional staff were deployed to meet patient need, such as when observation levels required additional staffing. The wards used bank staff who were familiar with the ward.
- Doctors were available to respond to medical needs.
- There were sufficient staff to carry out physical interventions Staff only used restraint after de-escalation had failed.
- With the exception of Mental Health Act training, staff were able to access required and specialist training.
- Risk assessments were in place and regularly updated.
- Restrictions on the wards were proportionate to the safety of the patients. We saw these were risk based and supported patient well-being.
- There were good policies and procedures for use of observation and searching patients.
- Rapid tranquilisation was used in accordance with National Institute of Clinical Excellence (NICE) guidelines.
- There were safe procedures for children visiting the wards.
- Staff reported incidents and there was evidence of learning from them. Staff debriefings and learning groups took place.
- Seclusion was used appropriately and monitoring and recording followed National Institute of Clinical Excellence (NICE) guidance.

Requires improvement



Summary of findings

Are services effective?

Good



We rated effective as good because:

- Care records were up to date, and contained relevant information to assist in a patient's recovery. Wards completed comprehensive and timely assessments after admission. The majority of care plans we sampled gave a full range of needs and were recovery-focused and contained evidence of informed consent and assessment of mental capacity.
- Mental Health Act documentation was in order, and regularly audited. There was good administrative support from the Mental Health Administration team, and patients had good access to Independent Mental Health Advocacy services.
- Medical records showed that the wards adhered to National Institute of Clinical Excellence (NICE) guidelines in prescribing medicines, including rapid tranquilisation
- Wards carried out clinical audits that helped improve the service.
- There were effective multi-disciplinary team meetings involving relevant health professionals. Teams sought patient and carers views on these.
- Doctors were based on wards during normal working hours and were available on call at other times when required. Psychologists were available on the acute wards.
- Staff, including bank and agency staff, received induction appropriate for their roles. Regular appraisals and supervisions took place and staff were able to receive specialised training.
- Staff were trained in the Mental Capacity Act and applying and recording issues of capacity and consent appropriately.

However:

- Mental Health Act training rates for staff were low. This meant staff could be unfamiliar with the Act, or were not up to date with their training. This meant they might be unaware of changes to the Act or the code of practice, so they might be acting outside the Act, or not in accordance with recommended practice.

Are services caring?

Good



We rated caring as good because:

- Staff interacted with patients in positive respectful ways. We had positive feedback from patients and carers, particularly on the PICU wards.
- Staff showed a good knowledge and understanding of the individual needs of patients.

Summary of findings

- The service consulted and involved patients and carers in patient care and treatment.
- Patients had good access to advocacy services.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- Acute wards had average bed occupancy rates of over 100%. The practice of sleepovers meant that patients were moved from wards at short notice and could return to a ward to a different bed or to no bed at all.
- Although activities took place across wards, teams of activity organisers working across all wards had taken the place of an activity organiser based on each ward. Staff felt this had reduced the amount of time activity organisers dedicated to each ward, and made them less familiar with specific wards and patients.

However:

- There were few out of area placements made. There were beds available in the two PICU units if required.
- Wards had a variety of rooms for activities, with supervised access to outside areas. Sherbourne ward had a particularly wide range of rooms for varying activities.
- Staff had made Sherbourne ward particularly homely and patient friendly.
- Patients were positive about food, and were able to raise concerns and were confident of having them listened to.

Requires improvement



Are services well-led?

We rated well-led as good because:

- Wards have made progress in rectifying issues identified in the previous inspection.
- Managers were able to monitor and identify training needs. Staff received regular appraisals, supervisions and debriefings as appropriate.
- There were sufficient staff to cover shifts. Although there was a heavy reliance on bank staff to supplement shifts, this was largely achieved by bank staff who were familiar with wards.
- Staff reported incidents. The service learnt from incidents, complaints and service user feedback.
- Staff were aware of the trust's values and objectives.
- Wards had information boards to monitor their progress in meeting performance targets.

Good



Summary of findings

- Morale was generally good, with staff committed to the well-being of patients. Good team work and mutual support was particularly noticeable on PICU wards.
- Staff were able to submit items to the trust risk register.
- Patient and carer feedback indicated that staff were open and transparent.
- PICU wards were preparing to apply Accreditation for Inpatient Mental health Services. This is The Royal College of Psychiatrists' accreditation programme.
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However:

- Mental Health Act training was not fully up to date.
- Wards were not always ensuring that ligature risks were being properly mitigated by observations and safe practice.
- The service was using the practice of 'sleepovers' for patients on acute wards without a clear demonstration of clinical benefit for the patients concerned.
- The service had not ensured the seclusion room supported the well-being of patients or staff.

Summary of findings

Information about the service

The acute wards for adults of working age and the psychiatric intensive care units (PICU) provided by Coventry and Warwickshire Partnership Trust are part of the trust's acute division. The wards are situated on two sites, the Caludon centre and St Michael's hospital.

The Caludon centre is in Coventry and has four acute wards for adults of working age:

- Westwood (female, 20 beds)
- Beechwood (male, 20 beds)
- Spencer (female, 14 beds)
- Hearsall (male, 20 beds)

The centre also has a psychiatric intensive care unit (PICU), Sherbourne ward, which has 11 male beds.

St Michael's Hospital in Warwick has two acute wards for adults of working age:

- Larches (male, 20 beds)
- Willowvale (female, 16 beds)

It also has a PICU, Rowans ward, which has five female beds.

The Care Quality Commission (CQC) last inspected acute wards for adults of working age and the psychiatric intensive care unit (PICU) in April 2016 as part of a comprehensive inspection of Coventry and Warwickshire Partnership Trust.

There were no Mental Health Act Reviewer visits between 1 April 2016 and 5 April 2017 to locations relating to Acute and PICU services

Our inspection team

The team that inspected the acute and PICU wards at the Caludon Centre and St Michael's hospital comprised two

CQC inspectors, a Mental Health Act reviewer, an expert by experience, two mental health nurses, a psychiatrist, an occupational therapist and a social worker. It split into two teams that each inspected four wards.

Why we carried out this inspection

We undertook this inspection to find out whether Coventry and Warwickshire Primary Care Trust had made improvements to its acute wards for adults of working age and psychiatric intensive care units since our last comprehensive inspection of the trust in April 2016.

When we last inspected Coventry and Warwickshire Primary Care Trust we rated acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. We rated this core service as inadequate for safe, requires improvement for effective, good for caring, and requires improvement for responsive and well-led.

Following the inspection in June 2016, we told the trust it must;

- ensure adherence to the guidance on mixed sex accommodation.

- take action to remove identified ligature risks and ensure that ligature risk assessments contain plans for staff to manage risks.
- take action to mitigate the risks posed by poor lines of sight on the wards.

We also told the trust it should ;

- ensure that patients have been informed of their rights to access an Independent Mental Health Advocate (IMHA) under section 132 Mental Health Act (MHA) and that this is documented in accordance with the MHA code of practice.
- ensure that consent to treatment documentation for patients detained under the Mental Health Act is completed correctly.
- ensure the safe disposal of waste medication.

Summary of findings

- should ensure blanket restrictions in relation to hot drinks and the charging of mobile phones are not in place, as per their own guidance.
- ensure restrictions are only used when clinically justified.

We issued the trust with a warning notice and two requirement notices associated with acute wards for adults of working age and psychiatric intensive care units. These related to

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

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 these services, asked a range of other organisations for information and sought feedback from patients, carers and staff at focus groups.

During the inspection visit, the inspection team:

- visited all eight acute wards for adults of working age and psychiatric intensive care units (PICU) at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 27 patients who were using the service, as well as two carers and an advocate
- spoke with the managers or acting managers for each of the wards
- spoke with 34 other staff members; including doctors, nurses, social workers and 3 student nurses
- attended and observed two hand-over meetings and three multi-disciplinary meetings.
- collected feedback from five patients using comment cards.
- reviewed 47 patient care records.
- checked 38 patient medication charts
- carried out checks on the medication management on three wards and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We had positive feedback from patients and very positive feedback from carers of patients on the PICU wards. Throughout, patients were positive about staff, telling us how caring and respectful they were and how well they listened. Patients were also generally positive about food, with positive remarks easily outweighing negative ones.

Similarly, patients were positive about the environment, particularly the cleanliness and the activities available. Notwithstanding some reports of aggressive behaviour from other patients, patients told us they felt safe on the wards. We saw many compliment cards on the PICU wards, particularly Sherbourne.

Summary of findings

Good practice

Sherbourne ward, although subject to a Private Finance Initiative, had managed very well to create a homely, welcoming and patient-friendly environment, which was commented favourably on by patients and visitors.

Areas for improvement

Action the provider **MUST** take to improve

Action the provider **MUST** take to improve

- The trust must ensure that ligature risks are reduced, and that where they exist, staff adhere to plans to mitigate them.
- The trust must ensure that patient well-being is not adversely affected by the practice of 'sleepovers', and that this practice occurs only to meet patient need.

Action the provider **SHOULD** take to improve

Action the provider **SHOULD** take to improve

- The trust should ensure that staff in acute and PICU wards receive up to date Mental Health Act training to equip them for their current roles.

Coventry and Warwickshire Partnership NHS Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Westwood, Spencer, Sherbourne, Beechwood, Hearsall	Caludon Centre
Rowans, Larches, Willowvale	St Michael's Hospital

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.

We found the service to be adhering to the Mental Health Act in practice and recording. Staff were completing detention papers correctly. There were clear records of leave granted to patients. Competent persons who were authorised to do so examined each detained patient's Mental Health Act paperwork on admission, and detained patients had their rights explained to them. Consent forms were attached to medication charts as appropriate, and there were regular audits to ensure that paperwork was being applied correctly. Independent mental health

advocacy (IMHA) support was readily available, and the service was pro-active in ensuring referrals were made unless patients specifically declined this. Patients told us they could see an advocate when they requested one.

However, levels of Mental Health Act training were very low, averaging 32% for level two and 13% for level 1 for this service. This was concerning, because although qualified staff had received training in the Mental Health Act at some stage in their career, lack of recent training meant they may not be up to date with changes to the Act and Code of Practice. Health care assistants told us they had no training in the Mental Health Act, and would ask qualified staff for advice and help if required.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that 95% of staff in this core service had received training in the Mental Capacity Act (MCA). Staff showed a good understanding of the issues of capacity and consent within patient groups. Staff on acute

wards showed a good awareness of the use of Deprivation of Liberty Safeguards. Capacity and consent forms were completed and stored appropriately. There was a trust policy on the MCA which staff were able to refer to.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Acute wards

Safe and clean environment

- There were ligature risks on acute wards. There were ligature risk assessment and management plans on each ward. These did not fully address risk in all areas, leaving potentially unsafe areas of risks. We were told that work was being done on a rolling programme to address all identified ligature risks. Work did not appear to have been prioritised to address the highest risk first. For example, wetroom on Larches had been made ligature free, but toilets, which were in frequent and open use, still had taps that were a ligature risk.
- External windows on acute wards at the Caludon centre contained latches and limiters that were potential ligature risks. Sherbourne PICU ward and one currently unused ward there had been refitted with suitable safe window but the acute wards had not. The style of safety fasteners that limited how far patients could open windows posed a particular dilemma. If the limiters were removed, patients could open the windows fully, putting them at risk of jumping or falling out. If they remained in place, they were a potential ligature risk. All wards had ligature risk assessments, but these did not always address the risks fully, or were not being consistently applied. On Hearsall ward, for example, the ligature risk assessment stated that all top windows were kept locked in the communal areas as they posed a ligature risk. We observed several of these were open.
- Staff on the wards told us that patients were risk assessed and observed, but it was not clear that this mitigated risk at all times on a busy wards where patients and patient needs fluctuated and changed. We noted, for example on Larches ward, a patient had been assessed as being at risk of self-harming but been placed in an en-suite room where there were ligature risks. Following the inspection, the trust gave assurances that there were specific reasons for this patient to be in this room, and observations levels reduced this risk.
- We spoke with the lead for suicide prevention who confirmed that the majority of self-harm and suicides (95%) were on female wards, and 95% of all ligatures were non-suspended ligatures (i.e. not from a ligature point). Where people were at risk, she stated that mitigation was observations, removal of obvious risks such as belts and wires, ready availability of ligature cutters and staff training in resuscitation. Nevertheless, she acknowledged there were potential risks, and that risk assessments needed to be adhered to, and that the rolling programme of removing potential risks was continuing. Ligature cutters were accessible on all wards.
- There were some parts of wards where staff could not clearly observe patients. Fish eye mirrors had mitigated risk in many areas, but there were still blind spots. These were recorded in the trust's most recent audit in 2017. Spencer ward for example, noted blind spots in corners of some bedrooms and in a corridor. These were mitigated in the risk assessments by staff awareness and observations.
- Acute wards were all same sex, three female wards and three male wards, two each at Caludon centre and one each at St Michael's hospital. No patient we spoke with made any comments, positive or otherwise, on this.
- There were no seclusion rooms on the acute wards. There was one seclusion room, for male patients on Sherbourne PICU ward. We report on this in the PICU section of this report.
- Each ward had a suitable clinic with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinics were clean and well organised. Rotas were in evidence showing staff checked and cleaned equipment regularly. Staff monitored drugs cupboards and fridges, checking and monitoring temperatures.
- Ward areas were clean and generally well maintained with good furnishings.
- PLACE surveys for cleanliness on all wards at Caludon scored 92.5% and at St Michael's 99%. For appearance and maintenance, Caludon scored 89% and St Michael's scored 92.5%. These were similar to trust and national average scores.
- Wards kept checks to ensure equipment was properly maintained and cleaned.
- Cleaning records were in evidence and regularly audited by ward managers.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Staff adhered to infection control principles including handwashing. Staff either carried or had access to cleaning gels placed at strategic and accessible points. We saw staff using these regularly.
- Environmental risk assessments were undertaken regularly.
- Staff carried personal alarms. In addition, call bells were in use and these alerted staff to the origin of the call. Staff responded to these promptly.

Safe staffing

- The acute wards had three registered nurses per shift and two health care assistants per shift, with two registered nurses and one health care assistant on each night shift. In addition, two health care assistants were employed on a 'twilight shift from 4-10pm. We looked at a sample of rotas and found staffing met these levels. There were mixed views from staff and managers about whether staffing was sufficient. Whilst most agreed that levels were safe, some felt that the need for patient escorts and observations sometimes meant that opportunities for activities became limited. Staff on Hearsall ward felt they were often short staffed.
- For the twelve months 1 February 2016 to 31 January 2017, totals for staff leaving this core service were slightly higher (15.4%) than the trust average (13.5%).
- Sickness rates for the same period were higher for this core service (8%) than the trust average (5.2%) Sickness rates were higher for wards at Caludon than for those at St Michael's hospital. The highest average sickness rates for this period on acute wards were on Beechwood (12.8%) and the lowest was on Larches (3.9%).
- Additional staff were deployed when patient need required it usually when observational levels were increased to ensure patient safety. There was a clear protocol as to when this need triggered the need for extra staff, and managers were aware of this. Managers and staff acknowledged that occasionally, last minute sickness might leave a shift initially short staffed, but this would be rectified by extra cover during the course of the shift.
- Acute wards all carried some vacancies that had to be covered by bank or agency staff. Figures provided by the trust showed qualified nurse vacancies for the twelve months 1 February 2016 to 31 January 2017 ranged from

19% on Hearsall ward to full complement on Spencer and Willowvale wards. For healthcare assistants during the same period, figures ranged from 32% on Beechwood ward to full complement on Hearsall ward.

- All ward managers said they were able to cover most vacancies with bank staff who were familiar with the ward, with only very occasional use of staff who were 'new' to the ward. New staff received inductions as required. Our observations and discussions with staff and patients confirmed that staff on wards were familiar with the environment.
- The ward managers were able to deploy additional staff when extra observation levels were required.
- We had one comment from a patient regarding nurses always being in the office doing paperwork, but nurses were generally present in communal areas, and patient comments reflected this.
- Staff and patients told us patients had regular 1:1 time with their named nurse or health care assistant.
- We did not see or hear of examples of escorted leave being cancelled, other than for clinical or patient-related reasons. Ward activities may have been limited at times, owing to availability of activity organisers, but staff used their initiative to set up relatively spontaneous activities with patients.
- There were enough staff to safely carry out physical interventions. Staff were able to call on other wards for assistance if needed. Staff explained how this worked effectively
- There were doctors based on wards to provide medical cover during working hours. At evenings and weekends there were on call doctors at the neighbouring hospital who could respond promptly to calls.
- Mandatory training figures for all acute wards as of January 2017 were 90% as against a trust target of 95%. However, at the time of the inspection, ward managers were able to show training figures for mandatory training figures had increased and were within the 95% trust target. Staff we spoke with talked positively about training.

Assessing and managing risk to patients and staff

- We looked at a sample of 34 care records on the acute wards. These showed staff undertook a risk assessment

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

of every patient on admission and updated this regularly and after every incident. Staff used recognised risk assessment tools, such as STORM (suicide prevention).

- Acute wards did not have seclusion facilities. If male patients required seclusion they had to be transferred to Sherbourne PICU ward at the Caludon centre. Trust figures for the twelve months to 31 April 2017 showed there had been six seclusions of patients from Hearsall and four seclusions of patients from Beechwood. There were no seclusions for female patients. The manager of Rowans told us female patients were never secluded.
- Trust figures for the twelve months to 31 April 2017 showed there were 260 episodes of restraint on the six acute wards. These were fairly evenly distributed, except that Westwood had by far the highest number of restraints, with 108. We were informed that thresholds for restraints were low, with many involving patients being led away from potentially volatile situations. Prone restraints could involve patients sitting down whilst being given medication. There were 33 prone restraints in total on the six acute wards over the same period. Beechwood and Spencer had the lowest, with two and three respectively, and Westwood had the highest with 13.
- Restrictions on the wards were proportionate to the safety of the patients. We saw these were risk based and supported patient well-being.
- Staff received training in a recognised approach to managing violence and aggression and were able to get advice and support concerning restraints. Staff were not allowed to take part in restraints until they had received the full training. Training figures received from the trust showed training on acute wards ranging from 70% for refreshed training on Larches to 100% on Spencer ward.
- Informal patients could leave when they wanted to, and we saw this happening. However, there were some informal patients who requested leave but were being nursed under close observation. This was prompted by safety concerns, and staff told us these were covered by contracts and agreements between patient and the ward.
- In line with national requirements the trust had introduced a smoke free policy. This means that no one is allowed to smoke on any of the trust sites. Staff and managers on many wards felt that the smoking ban had created problems for the wards and staff. On Hearsall ward staff commented that all patient leave was focused on smoking and they also felt that not being able to smoke increased anxiety and aggression for some patients. They felt that senior management did not appreciate the additional burden this placed on staff. Senior staff monitored smoking related incidents, electronic cigarettes and nicotine replacement were available to patients.
- There were policies in place for use of observation (including to minimise risk from ligature points) and searching patients. We saw staff adhering to observation practice and ensuring they were doing and recording observations in line with required levels.
- Trust figures for the twelve months to 31 April 2017 showed that rapid tranquilisation had been used on 98 occasions on the six wards. The highest during this period was on Westwood with 33 instances, and the lowest on Beechwood with 11 incidents. All wards followed NICE guidance. An up to date policy covering rapid tranquilisation, based on the current NICE guidance NG10 dated May 2015, was available. It advised staff how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. We found the prescribing to be in line with the policy and NICE guidelines and that the monitoring of patients vital signs post rapid tranquilisation, was well documented in the patient records.
- Staff were trained in safeguarding and knew how to make a safeguarding concern and do so when appropriate. Staff gave examples of safeguarding concerns which showed they had a good awareness of safeguarding issues, how to report them and to who. Staff awareness included concerns about patients being abused, financially or otherwise, outside the ward environment.
- We inspected clinic rooms where medicines and medication records were stored and found that medicines were stored appropriately, recorded and administered properly. Wards recorded and monitored temperatures in medicines fridges and clinic rooms. Where they had exceeded temperatures, as had happened in recent hot weather, mitigating measures, such as installing air conditioners, had taken place, and pharmacy advice taken about disposing of any affected medicines. Clinic rooms were tidy, medicines were stored correctly, and dispensing records were in line with policy and guidelines.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- There were safe procedures for children that visited the ward. Wards had rooms outside the immediate ward where patients could meet families and children as appropriate. These were risk assessed, with staff either in direct attendance, or nearby.

Track record on safety

- There had been nine serious incidents in the last 12 months across the six acute wards. Four of these had been on Spencer ward.
- Examples of adverse events were given such as an assault on a member of staff trying to remove a lighter from a patient, and a fire in a patient's bedroom.
- Managers told us of a rolling programme to reduce the potential risk from ligature points.
- One incident occurred immediately prior to our visit, where a patient had attempted to self-ligature using surgical tape obtained from a clinic room. This showed the importance of ensuring patients were properly monitored during any time spent in the clinic room.

Reporting incidents and learning from when things go wrong

- All staff we spoke with were clear on what incidents to report and how to report them. They gave us examples of incidents and concerns they had reported along with actions the service had taken. A fire in a patient's bedroom had resulted in reinforcing of the no-smoking policy. Staff commented that many incidents were smoking related, either directly, through a fire, or indirectly through a patient becoming agitated at not having opportunity to smoke.
- Staff gave us examples of feedback they had from incidents. Issues such as verbal aggression, smoking in rooms and drug use, were discussed in ward rounds.
- Staff were open and transparent and explained to patients if and when things had gone wrong.
- Staff attended debriefings and learning groups. A member of staff gave an example of how debriefing and psychology support had helped the team better manage and support a patient who had become aggressive and abusive towards staff.
- We had examples where changes had been made to the service following feedback.
- Staff were able to attend either group or individual debriefings and were offered support after serious incidents. There were individual de-briefings and

mutual help meetings to support staff. One health care assistant on Spencer ward spoke of the value of debriefs after an incident. They said 'it really helps to offload how you feel.'

Psychiatric Intensive Care Units

Safe and clean environment

- The ward layout allowed staff to observe all parts of ward.
- There were no ligature points – or the risk was adequately mitigated by patients only having supervised access to such areas. All rooms were en-suite and had anti ligature fittings.
- The two wards were single sex. Rowans was an all-female ward and Sherbourne was an all-male ward.
- Clinic rooms were clean and tidy. Staff checked emergency equipment daily and managers audited checks weekly.
- There was one seclusion room on Sherbourne ward for male patients. The seclusion room had a toilet, but there was no facility for two-way communication, which meant staff had to shout through the door. There was a clock, but this could only be seen from the toilet. There was only one small window, which could not be opened. The seclusion room was situated in the middle of the ward, and could only be accessed via a short but narrow corridor, which meant it could be difficult to get a person safely into seclusion. The manager informed us they were expecting a redesigned seclusion room and intended to view other seclusion rooms to inform proposals for an improved seclusion room. There had been a recent incident where a staff member had been injured through contact with the narrow door whilst a patient was being placed into the seclusion room.
- Both wards areas were clean, with good furnishings and were well-maintained. PLACE surveys for cleanliness on all wards at Caludon scored 92.5% and at St Michaels 99% and for condition appearance and maintenance, 89% on Caludon and 92.5% on St Michael's.
- Staff adhered to infection control principles including handwashing, with anti-bacterial gel available and routinely used by staff.
- Equipment was clean and well maintained. The drugs cupboards and fridges were in good order.
- A cleaning schedule was in place and adhered to. Our observations of the cleanliness of the wards were

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

confirmed by positive remarks about the cleanliness by carers of two patients who were using the service.

Amongst their compliments, they praised the cleanliness of the wards.

- Audits of the wards ensured environmental risk assessments were taking place and updated as required.
- All staff had personal alarms and wall mounted alarms indicated where attention was required. When these sounded staff were prompt in locating the source of the alarm and offering support as required.

Safe staffing

- There were adequate numbers and grades of nurses to meet safe staffing levels. For Sherbourne ward, an 11-bedded ward, this was five registered nurses per shift and five health care assistants per shift, with three of each on each night shift.. For Rowans ward, a five bedded unit, safe levels were three qualified nurses and two health care assistants per day shift, with two of each on nights. In addition, two health care assistants were employed on a 'twilight' shift from 4-10pm.
- Staff turnover figures for acute and PICU wards for the twelve months 1 February 2016 to 31 January 2017 were slightly higher for this core service (15.4%) than the trust average (13.45%).
- Sickness rates for the same period were higher for this core service (8%) than the trust average (5.2%) Sickness rates were higher for wards at Caludon than for those at St Michael's.
- Average sickness rates were 6.7% for Sherbourne and 3.3% for Rowans.
- Vacancies for this period were 25% for nurses on Sherbourne and 19% on Rowans, and 25% for healthcare assistants on Sherbourne and 15% on Rowans.
- Additional staff were deployed when patient need demanded, mostly when observational levels were increased to ensure patient safety. Managers and staff acknowledged that very occasionally last minute sickness might leave a shift initially short staffed, but this would be rectified by extra cover during the course of the shift.
- The service used bank and agency staff when required to cover vacancies and absence. There were 4.6 current

vacancies on Sherbourne ward for qualified nurses, and six vacancies for health care assistants. On Rowans ward, as of 31 January 2017 there were 2.4 vacancies for nurses, and 2.5 vacancies for healthcare assistants.

- The wards used bank staff who were familiar with the ward, with only occasional use of staff who were 'new' to the ward. Inductions were given to staff as required.
- The ward managers were able to deploy additional staff when extra observation levels were required. Managers explained the process for this, whereby the ward was able to obtain staff promptly from a central resource.
- We saw qualified nurses present on the communal areas of the ward at all times. Feedback from staff, patients and carers confirmed this.
- There were enough staff so that patients could have regular 1:1 time with their named nurse. Patients spoke favourably of their named nurses and of health care assistants.
- Escorted leave or ward activities were rarely cancelled because there were too few staff. One patient felt that patients who smoked got priority for leave. Activity organisers were in evidence; staff were also able to engage in more spontaneous activities with patients. We observed good interactions between patients and staff in activities such as table tennis.
- There were enough staff to safely carry out physical interventions. Staff told us other wards sometimes called upon them to assist in the event of an emergency. Staff were clear that those on patient observation duties remained to complete observations as required.
- There were doctors based on wards to provide medical during working hours. At evenings and weekends there were on call doctors at the neighbouring hospital who could respond promptly to calls.
- Mandatory training figures for all acute wards as of January 2017 were 90% against a trust target of 95%. Areas that may be considered particularly pertinent to PICU wards that were below trust targets were resuscitation 76%, basic life support 89% and manual handling 28% However, managers told us that training was now up to date, and were able to show us figures that showed mandatory training was taking place to an acceptable level.

Assessing and managing risk to patients and staff

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- We looked at a sample of 13 care records on the PICU wards. These showed that staff undertook and regularly updated risk assessments recognised using risk assessment tools.
- There were 78 episodes of seclusion in the twelve months until 30th April 2017 on Sherbourne ward, averaging 6.5 per month. The manager told us there had been five in June. The ward very occasionally accepted patients from other wards. Data provided by the trust showed there had been six seclusions of patients from Hearsall, and four from Beechwood in the twelve months to 30th April 2017. Seclusion was used appropriately and monitoring followed NICE guidance. The manager advised that the usual stay in seclusion was 2-3 hours, but 'may be longer.' We noted and discussed one lengthy period of seclusion with a staff member. There were valid reasons for this stay. The records for seclusion were kept in an appropriate manner and showed the ward carried out reviews and checks out appropriately.
- There were 107 episodes of restraint on Sherbourne ward, and 89 on Rowans ward in the same period. There were 25 episodes of prone restraints on Sherbourne ward, and 16 on Rowans ward over those twelve months. Prone restraints were used for minimal periods.
- Restraint was only used after de-escalation had failed and used correct techniques. All staff were trained in restraint. Staff received training in a consistent approach to managing actual or potential aggression and were able to get advice and support concerning restraints. Training figures received from the trust showed training on acute wards ranging from 80% for refresher training on Rowans to 88% on Sherbourne ward. Staff were not allowed to take part in restraints until they had received the full training. We saw good examples of staff de-escalating situations where patients became agitated, in one instance guiding a patient who had become angry towards a relaxation room where they were able to talk things through and reduce his agitation.
- Staff consistently told us that prone restraint was rarely used and patients were immediately repositioned following a prone restraint. Staff were also consistent in telling us that training and support was extremely good and gave them confidence that when restraint had to be used they could use it correctly and with a consistent team approach.
- Restrictions on the wards were proportionate to the safety of the patients.
- There were no informal patients on the PICU wards.
- There were good policies and procedures for use of observation (including to minimise risk from ligature points) and searching patients.
- The manager on Sherbourne was able to quote the relevant NICE guidelines they followed for rapid tranquilisation and seclusion.
- In the twelve months up to 30th April there were 62 incidents of rapid tranquilisation on Sherbourne, and 44 on Rowans ward. An up to date policy covering rapid tranquilisation, based on the current NICE guidance NG10 dated May 2015, was available. It advised on how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. We found the prescribing to be in line with the policy and NICE guidelines and that the monitoring of patients vital signs post rapid tranquilisation, was well documented in the patient records.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and do so when appropriate. Staff gave examples of when they had identified and dealt with safeguarding enquiries. This showed they had a good awareness of safeguarding issues and how to report them and to who, including concerns about patients being abused, financially or otherwise, outside the ward environment.
- We inspected clinic rooms where medicines and medicines records were stored and found that medicines were stored appropriately, recorded and administered properly. Temperatures were recorded, and where they had exceeded temperatures, as had happened in the recent hot weather, mitigating measures, such as installing air conditioners, had taken place. Clinic rooms were tidy, medicines were stored correctly, and dispensing records were in line with policy and guidelines.
- There were safe procedures for children to visit the ward. Wards have rooms outside the immediate ward where patients can meet families and children as appropriate. These were risk assessed, with staff either in direct attendance, or nearby.

Track record on safety

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- There had been two serious incidents in the 12 months up to January 2017 on the PICU wards. One related to self-harming that met the serious incident criteria.
- Information about adverse events that are specific to this core service.
- There were improvements in safety to this core service. Examples of these are discussed in the next section.

Reporting incidents and learning from when things go wrong

- All staff we spoke with were clear on what to report and how to report it. They gave us examples of incidents and concerns they had reported along with the actions that had been taken.
- The manager of Sherbourne told us of a patient who had ingested alcohol based hand sanitiser gel. This had resulted in the service using a different hand gel that would be less likely to be misused. A carrier bag had been misused by a patient. The ward had consequently added such bags to the list of restricted items. We saw the ward enforcing this ban in a patient-friendly manner, with a patient returning to the ward with a bag being observed taking it to their room to unload their purchases, before being politely requested to give the bag to the member of staff, who was ready to remind them of the reasons for this.
- We saw staff appropriately reporting incidents during our visit.
- Staff were open and transparent and explained to patients if and when things went wrong. One patient told us 'staff let me know if there is a problem about anything.'
- Staff gave us examples of feedback they had from incidents. They told us they were informed of incidents in other parts of the service so they could learn from these.
- Staff had debriefings and learning groups. These were led by the consultant, who supported staff in raising issues and looking at how things might be handled differently. Staff were also offered individual debriefings where necessary.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Acute wards

Assessment of needs and planning of care

- We looked at a sample of 34 patient care records across the acute wards. These were mostly on paper. The service was in the process of changing from paper to electronic records.
- We saw that the wards completed comprehensive and timely patient assessments after admission.
- Care records show that a physical examination has been undertaken and that there was ongoing monitoring of physical health problems. One manager felt the service would benefit from having more nurses who were also qualified in general nursing to better monitor physical healthcare needs.
- Care records were up to date, and contained relevant information to assist in a patient's recovery.
- All information needed to deliver care was stored securely and available to staff when they need it and was in an accessible form.

Best practice in treatment and care

- Medical Records showed that the wards adhered to National Institute of Clinical Excellence (NICE) guidelines in prescribing medicines, including rapid tranquilisation. Two patients had been administered intramuscular medicine for managing violence and aggression and in both instances staff had monitored the vital signs of the patient as per NICE guidance. One patient was prescribed medicine for rapid tranquilisation and this was in line with NICE NG10 guidance.
- Psychologists were available on the acute wards. We had examples where psychologists had supported staff to better understand complex patient behaviours and also worked on an individual basis with particular patients. Although staff often felt psychology input could be greater, they felt it was invaluable, both in reflective learning and in looking at the best ways to work with particular patients.
- Doctors were based on the wards during normal working hours and were available on call at other times when required. Their presence ensured good physical healthcare was available and prioritised for those in particular need.

- Recognised rating scales to assess and record severity and outcomes were used by the service, such as HoNOS (Health of the Nation Outcome Scales) and STORM (suicide prevention).
- We saw and discussed examples of clinical audits with staff that were carried out and had helped to improve the service. Mattress audits had helped identify continence issues for particular patients and enabled support and treatment to be started. A safety audit had resulted in changes and improvements to alarms. A weekly management audit covered key areas to ensure wards were working effectively.

Skilled staff to deliver care

- Multi-disciplinary teams included occupational therapists, nurses, consultants, care co-ordinators, with input from psychologists, patients, carers, and healthcare assistants. Crisis teams were invited as a part of information sharing and preparing for discharge.
- There was a suitable mix of experienced and qualified staff. Health care assistants were supported by clinicians and qualified staff.
- Staff including bank and agency staff received induction appropriate for their roles. We spoke with a recently recruited staff member who was in the process of completing their induction and felt confident and well supported. They told us how they had been able to 'shadow' until they were competent and confident to work on a shift as part of the shift and that their induction was still on-going and that the manager and other senior staff were always available for support and advice. We spoke with student nurses who detailed the extensive induction and support they received.
- The trust provided appraisal rates for the period 1 February 2016 – 31 January 2017. During these 12 months, Hearsall, Willowvale and Larches met or exceeded the trust target of 95% for both nursing staff and healthcare assistants. Spencer (92%), Westwood (91%) and Beechwood (84%) had not quite reached this target.
- All medical staff on all acute wards were up to date with their revalidation.
- The trust provided figures for clinical supervision rates for nursing staff for the period 1 February 2016 – 31 January 2017, Westwood, (78%) Hearsall (50%) and Larches (48%) were considerably below the trust 95% target. Managers showed how these figures were improving in recent months. Staff we spoke to on all

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wards told us they were receiving regular supervision. Staff spoke of regular supervision and how it was useful, allowing them to express concerns or suggest things that may help the ward.

- Staff were able to receive specialist training for their role. A healthcare assistant told us they were accepted recently on 'blood training' (phlebotomy).
- Ward managers did not report any major issues with staff performance. Where there were issues, such as staff members not gelling in teams, managers were able to explain how this was dealt with.

Multi-disciplinary and inter-agency team work

- There were regular and effective multi-disciplinary meetings. These took place three days a week, in the form of ward rounds. They primarily involved consultants and nurses, but patients, carers, and other health professionals would be involved as required.
- Wards had daily handovers, in the morning and at night. The trust had introduced a policy reducing these to ten minutes, across all wards. Some staff we spoke with thought this was insufficient, and handovers sometimes took longer. One told us that handovers rarely finished within the ten minutes and were completed in staff's own time. On some wards, handovers were by an information board to provide a 'handover at a glance, as well as a book that was updated throughout the shift to pass on. Some wards had a mini multi-disciplinary meeting in the morning, where staff got together to discuss the main current issues with patients.
- Managers told us there were good relationships with other teams within the organisation such as crisis teams. A manager explained how crisis teams would be involved in the discharge process and would be inform and offer appropriate support when an informal patient discharged themselves. They gave an example of a patient who went out on leave but decided not to return and whose needs were 'picked up' by the crisis team. We heard very positive comments about the support given by the south Warwickshire crisis team.
- One manager felt that acute wards and PICU wards could work more closely and effectively. They gave an example of an occasion when they felt a PICU ward was being overly resistant to accepting a patient from the acute ward.

- Wards worked to forge good relations with other organisations who were likely to be able to provide accommodation and support for patients in future. Wards said they had a good relationship with the police.

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

- In addition to our examination of care records, we looked in detail at a sample of six records specifically related to the Mental Health Act. We found detention papers were completed correctly. A competent and authorised staff member examined Mental Health Act papers on admission.
- Staff were aware the availability of the Mental Health Act administrative team. Staff said they were approachable and helpful.
- We saw clear records of section 17 leave granted to patients. Patients signed leave forms as appropriate.
- Health care assistants told us they had no training in the Mental Health Act, and would ask qualified staff for advice and help if required. Current Mental Health Act training figures for acute wards for acute wards were very low. Willowvale had achieved 71% in level two and 18% in level one; all other acute wards were 27% (Larches) or below in level two, with several wards having zero percentage figures for training in level one. This was concerning, for although qualified staff had received training in the Mental Health Act at some stage in their career, lack of current training meant they may not be up to date with changes to the Act and Code of Practice.
- Patients had their rights under the Mental Health Act explained to them on admission and when necessary thereafter.
- Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached to medication charts where applicable.
- We saw that detention paperwork was filled in correctly, was up to date and stored appropriately.
- There were regular reviews and audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from any errors.
- We heard consistently good feedback from staff about the availability and presence of Independent Mental Health Advocacy (IMHA) services. Patients told us they

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

could see an advocate when they requested one. Staff told us they automatically referred patients to the IMHA service, unless patients specifically requested them not to.

Good practice in applying the Mental Capacity Act

- Trust figures for April 30th 2017 for staff training in the Mental Capacity Act showed an average 95% compliance. Larches (94%) Hearsall (92%) and Beechwood (90%) were just below this. The other acute wards were at or above this percentage.
- Staff we spoke with about Deprivation of Liberty Safeguards (DoLS). They were able to explain the process and reasons for making such a referral. Between 1 March 2106 and 28 February 2017 there were five DoLS applications made from acute wards.
- Staff we spoke with showed a good understanding of issues of capacity and consent within the patient group.
- There was a trust policy on the Mental Capacity Act available for staff to refer to if needed.
- Staff were aware that patients could have fluctuating capacity and recorded capacity to consent accordingly. Where required, capacity forms were completed by nurses and overseen by an independent consultant. We saw capacity and consent statements attached to medication charts.
- Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- There were arrangements in place to monitor adherence to the MCA within the Trust.

Psychiatric Intensive Care Units

Assessment of needs and planning of care

- We looked at a sample of 13 care records on the two wards. These were mostly paper records. The service was in the process of changing from paper to electronic records.
- We saw that staff undertook comprehensive and timely assessments after admission.
- Care records showed that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems for patients.
- Care records were up to date, and contained relevant information to assist in a patient's recovery. The

majority of care plans we sampled identified a full range of needs, were recovery focused and contained evidence of informed consent and assessment of mental capacity. Mental Health Act documentation was correct. Patients were able to have a copy their care plan. Care plans also contained patients' views about their care.

- All information needed to deliver care was stored securely and was available to staff when they need it and in an accessible form.

Best practice in treatment and care

- Records showed that the wards adhered to NICE guidelines in prescribing medicines, including rapid tranquilisation. We looked at a sample of recent rapid tranquilisation records. Three patients had been prescribed intramuscular medicine (IM) for rapid tranquilisation that followed NICE "NG10 2015" guidelines. Two patients had been administered the IM medicine for managing violence and aggression and in all incidents staff had monitored the vital signs of the patient in line with NICE guidance.
- Sherbourne ward had not had a psychologist on the ward since October 2016, but were recruiting to fill this position. They explained the personal circumstances for this shortfall. Rowans ward had access to a psychologist who regularly visited the ward.
- There was good access to physical health care when needed. We had very positive feedback from the carers of a patient on Sherbourne, that showed how specialists and staff attention ensured good physical health was available and prioritised for those in particular need.
- Recognised rating scales to assess and record severity and outcomes for patients were used by the service, such as HoNOS (Health of the Nation Outcome Scales) and STORM (suicide prevention).

Skilled staff to deliver care

- Multi-disciplinary teams (MDTs) included occupational therapists, nurses, consultants, care co-ordinators, with input, carers, and health care assistants and full involvement of patients.
- There were suitable levels of experienced and qualified staff on the PICU wards. Sherbourne had a core group of staff who, like the manager, had worked on the ward for many years. This core group were able to provide support for newer, bank or agency staff

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff, including bank and agency staff, received an induction appropriate for their role. We spoke with a recently recruited staff member who was in the process of completing their induction and felt confident and well supported.
- Staff on PICU were achieving 100% appraisals for both nursing staff and healthcare assistants.
- Staff had 100% revalidation; clinical supervision rates were 94% on Rowans and over 100% on Sherbourne ward.
- Staff were able to receive specialist training for their role. The manager on Sherbourne ward gave an example of healthcare assistants who were having training on phlebotomy and electrocardiogram (ECG) training to help equip them for work in this area.
- PICU managers told us they had no issues with staff performance. The manager of Sherbourne gave examples from the past that showed the service was pro-active in identifying and supporting staff where performance had, or was at risk of becoming an issue adversely affecting patient care.

Multi-disciplinary and inter-agency team work

- There were regular and effective multi-disciplinary meetings. These took place on three days of the week, with specific days to invite carers and relatives.
- Wards had handovers. The trust had instituted a policy reducing these to ten minutes, across all wards. Some staff we spoke with thought this was insufficient, and handovers sometimes took longer, with staff attending in their own time.
- Managers told us there were good relationships with other teams within the organisation. They mentioned the crisis teams as being particularly helpful in supporting patients and sharing information about patient needs and risks.
- Wards worked to forge good relations with other organisations who were likely to be able to provide accommodation and support for patients in future. Wards said they had a good relationship with the police.

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

- In addition to our examination of care records, we looked in detail at a sample of four records specifically

related to the Mental Health Act. We found detention papers were completed correctly. Mental Health Act papers were examined by a competent and authorised staff member on admission.

- Staff were aware the availability of the MHA administrative team. Staff said they were approachable and helpful.
- We saw clear records of section 17 leave granted to patients. Patients signed leave forms as appropriate.
- Health care assistants told us they had no training in the Mental Health Act, and would ask qualified staff for advice and help if required. Current Mental Health Act training figures for PICU wards were low. Sherbourne had achieved 53% in level 2 and 29% in level 1. Rowans 44% in level 2 and 21% in level 1. This was concerning, for although qualified staff had received training in the Mental Health Act at some stage in their career, lack of current training meant they may not be up to date with changes to the Act and the Mental Health Act Code of Practice.
- Patients had their rights under the Mental Health Act explained to them on admission and as necessary thereafter.
- Staff adhered to consent to treatment and capacity requirements and attached copies of consent to treatment forms to medication charts where applicable.
- Staff filled in detention paperwork correctly, was up to date and stored appropriately.
- Staff carried out regular reviews and audits to ensure that the MHA was being applied correctly and there was evidence of learning
- We heard consistently good feedback from staff about the availability and presence of Independent Mental Health Advocacy services. Patients told us they could see an advocate when they requested one. Staff told us they automatically referred patients to the IMHA service, unless patients specifically requested them not to.

Good practice in applying the Mental Capacity Act

- Trust figures for January 2017 for staff training in the Mental Capacity Act (MCA) were 95% for Rowans and 97% for Sherbourne, as compared to overall compliance for the trust of 95%.
- There were no Deprivation of Liberty Safeguards (DoLS) applications made on the PICU wards.
- Staff we spoke with showed a good understanding of mental capacity issues.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- There was a policy on Mental Capacity Act available for staff if needed for staff to refer to.
- Staff were aware that patients could have fluctuating capacity and recorded capacity to consent accordingly. Where required, capacity forms were completed by nurses and overseen by an independent consultant. We saw capacity and consent statements attached to medication charts.
- Wards supported patients to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. One staff member we spoke with gave an example of a patient who made poor decisions that worried some of the team, but they recognised the patient had the capacity to make such choices.
- There were arrangements in place to monitor adherence to the Mental Capacity Act within the Trust.

Are services caring?

Good 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Acute wards

Kindness, dignity, respect and support

- We observed staff interacting with patients in positive and respectful ways. On Larches, for example, we saw good engagement between staff and patients. We noted very attentive health care assistants. We received a very complimentary communication from an on call doctor who praised a health care assistant for their commitment and respectfulness and positive manner throughout a 'very hectic' recent shift.
- We had some feedback from one staff to the effect that some agency staff were not as responsive to patient needs, either through lack of knowledge or motivation, as permanent staff.
- On acute wards, patients we spoke with were generally very complimentary about staff. Some patients were unhappy because they did not believe they needed to be detained. Others spoke of feeling safe and of kind and respectful staff who listened to them. Some patients had spoken about incidents of aggression from other patients, but said that staff helped them feel safe. Where there were negative comments about staff and food and the environment, these tended to come from informal patients. We saw no examples of patients being turned away or being asked to return later because staff were busy. One patient told us "I have confidence in the staff". We heard of only one example where a patient was not attended to quickly and this was by a member of agency staff.
- The PLACE survey for privacy, dignity and wellbeing at St Michaels (92.2%) and Caludon (90.2%) was just above the national average of 89.7%.

The involvement of people in the care they receive

- Staff told us how they showed patients around the wards and how they explained what support was available in acute care. One member of staff explained how they tailored this to patient need and wishes. They would talk to individual patients about their care needs and how the ward would meet these.
- Doctors, nurses and patients discussed patient treatments in ward rounds. Doctors discussed the benefits of treatments. Clinicians listened to patients' concerns and treatment was sometimes amended to

reflect those concerns or wishes. This was not always evident in care plans, but our observations, discussions with patients, carers and staff showed that patients were involved in their treatment, with options and changes agreed between them and consultants. We observed patients and carers being fully informed and consulted during ward rounds, with doctors engaging well with patients to make them feel relaxed and comfortable. One member of staff told us how they tried as much as possible to involve patients in their care plans, but that sometimes patients were too unwell or did not wish to sign or participate in care plans.

- A nurse on Larches ward told us of a weekly pharmacy group where patients could ask questions or raise concerns regarding medication. All wards had patient groups where patients could raise issues and have them addressed. We received favourable patient comments regarding how they were able to raise issues. There were mutual help meetings, which gave opportunities for staff and patients to share ideas and concerns.
- Patients had access to both general and Mental Health Act advocacy. There were posters and leaflets detailing contacts, and advocates visited the wards regularly.
- Families and carers were informed of, and invited to, specific meetings where patients' recovery and goals were discussed.

Psychiatric Intensive Care Units

Kindness, dignity, respect and support

- We observed staff interacting with patients in positive and respectful ways.
- On Rowans ward, patients told us that staff worked well to keep patients safe, informed and involved in activities. They listened and acted upon patients' concerns. Comments we received from carers showed an extremely positive view of the support and care offered by staff. In addition, we saw a great many examples of compliments from carers and ex-patients regarding the support and commitment shown by staff towards patients.
- Staff showed a good knowledge and understanding of the individual needs of patients. For example, they were aware when one new patient was starting to become agitated and potentially aggressive. As part of the patient's de-escalation plan, staff calmly suggested a

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

relaxation area where he could have a quiet space to talk through his issues with staff. They also re-assured another patient who they saw was likely to be upset by the other patient being agitated.

- The siting of the seclusion room on Sherbourne ward had a potential adverse effect on the privacy and dignity of patients, as it was sited off the middle of a corridor.

The involvement of people in the care they receive

- The manager of Sherbourne explained that patients were shown around and given all necessary information about the ward, but that sometimes this process was delayed or repeated at suitable times, as patients were often too unwell upon admission to fully take in the information.
- Patients on both PICU wards were actively involved in their care and treatment. This was not always evident in care plans, but observations, discussions with patients, carers and staff showed that patients were involved, particularly in treatment, with options and changes agreed between them and consultants.
- Patients had access to both general and Mental Health Act advocacy. There were posters and leaflets detailing contacts, and advocates visited the wards regularly.
- There were regular patient groups where patients could raise issues.
- Families and carers were involved. On Sherbourne, relatives and carers were invited to two of the three weekly ward rounds. We had positive feedback from carers about how they were involved and listened to.

Are services responsive to people's needs?

Requires improvement 

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Acute wards

Access and discharge

- Acute wards had average bed occupancy rates of over 100%, with averages ranging from Beechwood at 106% to Spencer at 119% in the twelve months from 1 March 2016 to 28 February 2017. This meant patients beds were on occasions used by other patients when they were on leave, and that when they returned, the same bed might not be available to them.
- Between 1 March 2016 and 28 February 2017 there were six out of area placements involving Acute/PICU wards. Staff told us that out of area placements were made for as short a time as possible, with the aim of having that patient locally placed as soon as possible.
- The service practiced 'sleepovers' which meant patients being identified as a patient who could sleep in another ward, normally a rehab ward, in order for another patient to be admitted in their place. This patient would return to the ward the following day, but would not necessarily have a bed, until one became vacant. There was a policy in place for this, as well as a patient sleepover checklist. We saw no evidence of patients moving wards in this manner for any clinical benefit. Staff we spoke with all talked of sleepovers as a way of being able to admit new patients who were urgently in need of a bed. We saw a copy of the patient sleepover checklist used to facilitate these moves. This made no mention of clinical benefits for the individual patient. It simply asked for yes/no responses to questions such as 'has the reason for the sleepover been explained to the patient and have they been told they will return to the ward in the morning?' and 'has the patient got capacity and have they consented to the sleepover?' One manager told us the move could be beneficial to patients, as it allowed them to move on to a rehab ward, if only for one night, and that patients liked what they saw as progress to discharge. We heard differing views, with staff saying most patients did not like the disruption and uncertainty it brought. One carer, in an otherwise very complimentary appraisal of the service, noted their relative was first admitted to a room that was dirty and had another patient's belongings in. This was a result, they believed, of them making way for their arrival by having a sleepover elsewhere. One patient on

Larches ward told us 'No bed when I returned from home' and 'tell staff to stop swapping beds about'. One manager spoke of the 'least risky' patients being selected for sleepovers. They said that patients due for leave or discharge usually agreed to have a sleepover, if they thought this would hasten their discharge. They said they now identified, in advance, suitable patients so they could be moved if the need arose. This clearly indicated that sleepovers were taking place to meet the needs of the service, in facilitating urgent admissions, rather than meeting the needs of individual patients. The trust's bed management policy stated that 'On occasion, current inpatients may be considered for "sleepover" on another ward or unit in order to free up a bed for a priority admission or transfer in from out of area. Figures given by the trust showed that in the three months 30 March to 1 July 2017 43 patients from acute wards in Caludon had 'sleepovers' 176 times at the rehab ward at Hawkesbury Lodge. Hawkesbury Lodge is on a different site, entailing a twenty minute drive from the Caludon centre. During the same period, there were 35 'sleepovers' at Hazelwood rehab ward in St Michael's from Larches ward.

- Managers told us they sometimes received patients in the evening. They say they would not discharge a patient that late in the day, but accepted there may be delays between a patient being discharged and being accepted by another ward. The practice of 'sleepovers' often involved patients being moved in the evenings.
- Some staff felt one of the issues affecting bed occupancy was the number of patients who came into the service with personality disorders rather than mental health issues. They felt that drugs and alcohol were an issue, and sometimes ex-patients would be outside the main building, smoking and drinking.
- There were beds available in the two PICU units if a patient required more intensive care. The male PICU was in Coventry, the female in Warwick. There were plans to relocate the female unit to Coventry, to sit alongside the male unit.
- Between 1 March 2016 and 28 February 2017, there were 37 delayed discharges from the six acute wards. Larches had 19 delayed discharges, Westwood had 13, Beechwood had three and Spencer had two. Hearsall and Willowvale recorded no delayed discharges in this period. Staff and managers consistently told us delays were caused by difficulties in finding suitable alternative accommodation.

Are services responsive to people's needs?

Requires improvement 

By responsive, we mean that services are organised so that they meet people's needs.

- Between 1 March 2016 and 28 February 2017, there were a total of 58 readmissions within 30 days of discharge to acute wards.

The facilities promote recovery, comfort, dignity and confidentiality

- Wards had a variety of rooms. There was a mix of locked and unlocked activity rooms. Wards had beanbags in some areas as an aid to relaxation. Wards had quiet rooms, some had gym equipment, and there were art and craft rooms.
- Patients could make telephone calls in private. Hand held telephones were available for patients to use.
- Wards had access to outside areas. A tennis court and basketball court was available for patients on Larches ward. Patients told us they enjoyed the activities such as playing football outside. There was an attractive outside garden space at Willowvale that had been renovated with the help of private sponsorship.
- Patients reported that food was good. On Larches, for example, a patient told us the food was 'very good - regular and varied.' One female patient on Spencer noted they found food difficult to chew because of dental problems. It was not clear if they had raised this issue or if staff were aware of it.
- The PLACE survey for ward food scored 98.8% overall for the Caludon centre and 97.6% for St, Michael's. This was above the trust and national average score.
- There were facilities to make hot food and snacks. On Larches, for example, there were specific times for drinks and snacks outside main meals, but patients could ask staff to make drinks outside these times.
- We saw very little evidence of patients personalising their rooms, other than a few personal possessions in rooms. On Larches, one patient told us they had been asked not to put things on walls, but another said they could put pictures up on walls. Staff told us the terms of the Private Finance Initiative Agreement by which the Hospital had been built, which meant it was difficult to make to changes such as putting up new pictures.
- There was secure storage for patients' belongings.
- There were activities taking place on the acute wards. On Larches for example, there was a gym, and a relaxation group. There were activities organisers, but staff also took the initiative to organise activities, including at weekends. Some staff felt that demands for escorts and observations sometimes meant that opportunities for activities became limited. This was not

a view shared by all wards. Activity organisers worked across all wards, devoting two or three days to each ward. Some staff felt this was not a good system, as organisers were not so aware of the risks and needs of patients on each ward, as they were seeing more wards less regularly. Some staff preferred it when each ward had its own activity organiser.

Meeting the needs of all people who use the service

- Corridors were wide and there were features such as assisted bathrooms to help meet the needs of patients with physical disabilities.
- Information leaflets were available. These were primarily in English, but staff and managers advised that the service had leaflets printed on demand in other languages when they were required. There was a good variety of information on treatments, local services and support networks, as well as patients' rights and how to complain. Notice boards highlighted who was on duty.
- Interpreters and signers were available when required.
- There was a choice of food to meet patients' religious and cultural dietary requirements. We noted menu options that were healthy and included halal, gluten free, vegan and diabetic choices. The service introduced these following requests from patients.
- Wards had suitable rooms to meet spiritual needs. Multi faith chaplains visited and patients could request specific spiritual advisors. Patients gave us examples of being supported to attend church.

Listening to and learning from concerns and complaints

- There were 11 formal complaints made regarding acute wards in the twelve months from 1 May 2016 to 30 April 2017. There were three each on Larches and Spencer, two each on Beechwood and Willowvale, one on Hearsall and none on Westwood. There were no outstanding common themes in the complaints. The trust responded to them and took appropriate actions.
- Patients appeared aware of how to make complaints. Staff explained how the patients were supported to complain. These would initially be attempted to be addressed at ward level, but if needed would be taken to a higher level for a response. Patients have been able to contact CQC directly with concerns and have done this by telephone.

Are services responsive to people's needs?

Requires improvement 

By responsive, we mean that services are organised so that they meet people's needs.

- Patients told us they could give feedback in meetings. One patient told us they would rather speak to staff than Patient Advice and Liaison Service if they were upset about something.
- Between 1 February 2016 and 31 January 2017, Beechwood received 13 compliments, Hearsall 12, Westwood 10, Willowvale five, Spencer three and Larches one.
- Staff managed complaints they could readily respond to such as missing laundry, informally. Where they felt they could not respond to the patient's satisfaction, it would be raised as a formal complaint.
- We saw examples where staff had acted on the findings of complaints and where these had modified practice.

Psychiatric Intensive Care Units

Access and discharge

- Sherbourne and Rowans wards both had bed occupancy rates averaging 97% in the twelve months from 1 March 2016 to 28 February 2017.
- Between 1 March 2016 and 28 February 2017 there were six out of area placements involving Acute/PICU wards. The manager for Sherbourne told us that out of area placements were made for as short a time as possible, with the aim of having that patient locally placed as soon as possible.
- The PICU managers gave examples of patients having access to a bed upon their return from leave.
- Patients were not moved between wards during an admission episode, unless this was justified on clinical grounds and was in the interests of the patient. There was one male PICU and one female PICU unit.
- Managers told us they sometimes admitted patients in the evening. They say they would not discharge a patient late in the day, but accepted there may be delays between a patient being discharged and being admitted by another ward.
- A bed was available in a PICU if a person required more intensive care, and was sufficiently close for the person to maintain contact with family and friends.
- Between 1 March 2016 and 28 February 2017, there were no delayed discharges from the two PICU wards. There were a total of 41 discharges for Sherbourne and 21 for Rowans ward.
- Between 1 March 2016 and 28 February 2017, there were 2 readmissions to Rowans ward and 8 re-admissions to Sherbourne ward.

The facilities promote recovery, comfort, dignity and confidentiality

- Sherbourne ward had a wide range of rooms to support care and treatment. Rowans was a smaller ward with a smaller range of rooms, having an activities room, a separate lounge, and access to a garden area. It shared a visitor's room with the adjacent acute ward. Sherbourne had a range of activity rooms that were designated for particular uses. There was a relaxation room, an electronic games room, an arts and crafts room, as well as other 'breakout' rooms allowing for a wide variety of activities.
- Patients could make telephone calls in private.
- There was access to outside space. Sherbourne had a basketball ring and outdoor gym equipment.
- Patients reported that food was good. The PLACE survey for ward food scored 98.8% overall for the Caludon centre and 97.6% for St, Michaels, including the PICU wards.
- There were facilities to make hot food and snacks.
- Patients were able to personalise bedrooms, but we saw very little evidence of this, other than a few personal possessions in rooms. Communal areas had been made homely, and art works helped brighten the ward. This was especially the case on Sherbourne ward.
- The wards had secure lockers for patients to store belongings safely.
- There were activities taking place during our visit. On Sherbourne, the table tennis table was a centre of activity, with staff engaging positively with patients over games of table tennis. There were activities organisers, but staff also took the initiative to organise activities, including at weekends.

Meeting the needs of all people who use the service

- Corridors were wide and there were features such as assisted bathrooms to help meet the needs of patients with physical disabilities. Sherbourne had two large ensuite bedrooms that could be used by patients with disabilities.
- Information leaflets were available. These were primarily in English, but staff and managers told us that the service had leaflets printed on demand in other

Are services responsive to people's needs?

Requires improvement 

By responsive, we mean that services are organised so that they meet people's needs.

languages as required. There was a good variety of information on treatments, local services and support networks, as well as patients' rights and how to complain. Notice boards highlighted who was on duty.

- Interpreters and signers were available when required.
- There was a choice of food to meet patients' religious and cultural dietary requirements. We noted menu options that were healthy and included halal, gluten free, vegan and diabetic choices. The service introduced these following requests from patients.
- There was access to appropriate spiritual support. Multi faith chaplains visited and patients could request specific spiritual advisors.

Listening to and learning from concerns and complaints

- There were four formal complaints made regarding PICU wards in the twelve months from 1 May 2016 to 30 April 2017; 3 regarding Rowans and 1 regarding Sherbourne ward. These were all responded to and appropriate

actions taken. There were no outstanding common themes in the complaints. Patients appeared aware of how to make complaints. Once patient we spoke with told us of a complaint they had raised with the trust.

- Between 1 February 2016 and 31 January 2017 Rowans received two compliments and Sherbourne ward received 20 compliments. Sherbourne displayed the compliments on the ward, which added to the bright and positive feel of the décor.
- Staff managed complaints they could readily respond to such as missing laundry, informally. Where they felt they could not respond to the patient's satisfaction, complaints would be raised formally, and be responded to by PALS, the hospital's patient complaints service. All the complaints were logged, formally in a paper folder, but more recently, electronically.
- We saw examples of where staff had acted on the findings of complaints and where these had modified practice. One example was where a vegan patient had complained about the lack of choices and changes to the menu were made based on this.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Acute wards

Vision and values

- Staff were aware of the trust's values and objectives. We saw posters displaying these.
- Team objectives reflected the organisation's values and objectives.
- Some staff we spoke with felt senior management, at board level could do more to visit wards to involve and listen to staff. Most wards reported that the chief executive had visited and was known to them, in some cases as a frequent visitor. Staff acknowledged that recent changes had brought about improvements but they still wished for greater contact with management.

Good governance

- Staff received mandatory training. Any shortfalls identified in training were addressed by managers. There were low rates of training in Mental Health Act training, although this was starting to improve.
- Staff received regular appraisals, supervisions, and debriefings as appropriate.
- There were sufficient numbers of staff of the right grades and experience to cover shifts. However, there was a reliance on regular bank staff to ensure staffing levels were maintained safely.
- The service learnt from incidents, complaints and service user feedback.
- Staff participated in clinical audits.
- Safeguarding, MHA and MCA procedures were followed.
- Each ward displayed a copy of their latest 'dashboard' which was an array of data showing how well they were doing against trust targets such as staff appraisals, sickness, bed occupancy, and length of stay. These enabled managers and staff to identify then concentrate on issues that were outliers. Staff on Hearsall ward commented they did not feel these figures were very meaningful.
- The ward managers felt they had sufficient authority and administrative support to run the wards.
- Staff were able to submit items to the trust risk register.

Leadership, morale and staff engagement

- Sickness rates for this core service were 8% on average, which was higher than the trust average of 5%.

- We did not hear of any bullying or harassment cases.
- Staff were aware of the whistleblowing process and knew how to use it.
- Staff told us they were able to raise issues of concern without fear of victimisation.
- Morale was mixed on the acute wards. One staff member mentioned they did not like the fact that because of very low pay increases for several years, shop workers now earned more than they did. They felt this was demoralising and had contributed to some people leaving. The wards on St Michaels were due to close and move to Coventry. This had an effect on morale, but we noted that morale was still generally good. Staff on Willowvale, for example, felt they had a really good team, which faced being broken up as many of the staff were reluctant move with the service to the Caludon centre in Coventry.
- There were opportunities for staff development.
- Team work and mutual support on acute wards was mixed. Some staff expressed concerns about the high level of bank and agency staff.
- Feedback from patients and carers we spoke with indicated that staff were open and transparent and explained to patients if and when something went wrong.

Commitment to quality improvement and innovation

- Larches ward told us about the men's group that staff were setting up, with medics leading on a weekly group to look at men's health. Larches had been nominated within the trust for a quality award in the category 'respect for everyone.'
- Beechwood ward told us of plans to visit other wards to share good practice. Health care assistants on Beechwood had noted that patients admitted to the wards sometimes had very few clothes, so they had set up a small store of suitable clothing to help patients in such situations.

Psychiatric Intensive Care Units

Vision and values

- The manager of Sherbourne ward was able to recall the trust's four core values immediately, saying that they were displayed on posters and leaflets. Team objectives and approaches reflected these.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- The managers and staff said they were well supported by local management, and were visited on occasion by more senior managers.

Good governance

- Staff received mandatory training. Any shortfalls identified in training were being addressed. There were low rates of training in Mental Health Act training, although this was starting to improve.
- Staff were appraised and supervised.
- There were sufficient numbers of staff of the right grades and experience to cover shifts. However, there was a reliance on regular bank staff to ensure staffing levels were maintained safely.
- Staff were frequently on the wards involved in direct care activities.
- Incidents were reported.
- Staff learnt from incidents, complaints and service user feedback.
- Staff participated in clinical audits.
- Wards followed safeguarding, Mental Health Act and Mental Capacity Act procedures.
- Each ward displayed a copy of their latest 'dashboard' which was an array of data showing how well they were performing against trust targets such as staff appraisals, sickness, bed occupancy, and length of stay. These dashboards enabled managers and staff to identify and concentrate on issues that were outliers.
- The ward managers said they had sufficient authority and administrative support. The manager of Sherbourne felt the management structure had improved in the past nine months.
- The ward was able to submit items to the Trust risk register.

Leadership, morale and staff engagement

- Sickness rates were 8% on average, higher than the trust average of 5%.
- We did not hear of any bullying or harassment cases.
- Staff were aware of the whistleblowing process.
- Staff told us they were able to raise issues of concern without fear of victimisation.
- Morale was high on the PICU wards. The wards at St Michaels were due to close and move to Coventry. This had an effect on morale, but we noted that morale was still high despite this on Rowans ward.
- There were opportunities for development.
- Team work and mutual support was evident on PICU wards.
- Feedback from patients and carers we spoke with indicated that staff were open and transparent and explained to patients if and when something went wrong.
- Staff were offered the opportunity to give feedback on services and input into service development.

Commitment to quality improvement and innovation

- Sherbourne and Rowans wards were preparing to apply for Accreditation for Inpatient Mental health Services. This is The Royal College of Psychiatrists' accreditation programme.
- The wards were members of NAPICU (National Association of Psychiatric Intensive Care Units) and had quarterly meetings and attended conferences. They found the NAPICU guides useful for learning and practice.
- Sherbourne ward had established protected learning time for staff, which the manager said allowed 'breathing space' and allowed the team to look at specific patient issues.

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 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The narrow entrance to the seclusion room posed a potential risk to patients and staff. This was a breach of regulation 15 (1)(b)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ligature risks were widespread on acute wards and were not consistently mitigated. This was a breach of regulation 12(2)(b)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The practice of 'sleepovers' was taking place primarily to meet organisational needs, rather than the needs of individual patients. This was a breach of Regulation 9.