Devon Partnership NHS Trust

Langdon Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Langdon Hospital is an NHS forensic hospital based in Dawlish in Devon and run by Devon Partnership NHS Trust.

We inspected the Dewnans Centre which has four medium secure wards with a total of 60 beds. The four wards are Ashcombe, Holcombe, Warren and Cofton. The Dewnans Centre supports people on a treatment pathway from acute forensic emergency admissions through to longer-term medium secure services and step down care as people's health and wellbeing improves. Ashcombe is an admissions assessment ward providing care to people with acute mental health conditions. Holcombe Ward is a treatment ward for people with complex mental health needs, including people with personality disorders. Warren and Cofton provide services to people whose mental health is stable with the care and treatment provided by the hospital. People can and have moved to low secure services from these wards.

We visited Avon House, a 14-bed longer stay low secure ward; Chichester House, a 15-bed shorter stay low secure ward; Owen House, a 16-bed open ward for men with complex mental health needs and Connelly house, a 6-bed rehabilitation unit.

There were many positive aspects to the care provided to people using the services at Langdon Hospital. Physical health assessments had been carried out and reviewed for all patients. Where appropriate, physical health needs were addressed as part of the patient's care plan. Patients had good access to primary health care.

Improvements had been made in care planning since our last visit. Care plans were comprehensive and specific to the needs of the patient, with the patient involved in their development. Care plans were re-evaluated and updated regularly. Plans to discharge the patient or move them towards less secure environments were included as part of the care planning process.

Robust arrangements were in place to ensure that leave under section 17 of the Mental Health Act was appropriate and authorised. Risk assessments were consistently completed for patients. Case records demonstrated that comprehensive risk assessments were completed, regularly reviewed and updated when needs or risks changed. These assessments were reflected in the care plans with measures identified to manage or mitigate the risks.

All patients were legally detained under the Mental Health Act 1983. All treatment had been given under an appropriate legal authority. Patients were informed of their rights under the Mental Health Act 1983 and were supported in exercising those rights.

Improvements had been made to the seclusion facilities in the Dewnans Centre since our last visit. Improvements were needed in the seclusion environments in Avon House.

Records were completed for incidents of seclusion but there was no seclusion log or register and so it was not possible to check that all incidents of seclusion had been recorded appropriately. Incidents of seclusion are reviewed locally by Ward Managers and Senior Nurses both at team and directorate level. The current recording does not ensure all the necessary details are available to enable effective monitoring of trends on a trust wide level.

Out of hours there were some delays in patients in seclusion being reviewed by a doctor. This was because the on-call doctor covered several inpatient sites which affected their availability.

We found incidents of patients being nursed in, and prevented from leaving, the extra care areas of Avon House and Chichester House. Whilst staff were in the room with the patients, as they were unable to leave this is seclusion. These had not been recorded as seclusion episodes by staff and there was a lack of clarity from some staff as to the definition of seclusion.

Staff found it hard to describe clearly the areas for improvement and action taking place at Langdon Hospital. There were a range of governance measures in place including the audit processes, meetings relating to governance processes and improvement plans, but these need to become embedded so they are meaningful to staff working in the hospital.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Learning from incidents and investigations took place, and appropriate changes were implemented.

Patients confirmed that they felt safe and supported by staff at Langdon Hospital and had no concerns about the ability of staff to respond to safeguarding concerns.

Care plans included the assessment and management of risk.

Staffing levels varied across the wards/units according to patients' needs. On the whole, patients and staff felt staffing levels were sufficient.

Are services effective?

We saw that clinical guidance and standards were implemented, such as that of the National Institute for Health and Care Excellence. We reviewed policies and procedures, observed clinical practice and multi-disciplinary discussions; these were in line with best practice guidance.

Audits were in place, such as infection control and medicines management. These were conducted on each ward on an ongoing basis to monitor the quality and safety of service provision.

We saw comprehensive involvement of health and social care professionals in patients' care.

Patients told us that staff were supportive and helpful. Staff knew how to respond to specific health and social care needs and were observed to be competent. Staff spoke confidently about the care practices they delivered and understood how they contributed to patients' health and wellbeing.

Are services caring?

Patients using the service understood the care and treatment choices available to them. They told us how they were helped to understand care and treatment choices.

Staff communicated with patients in a respectful way. Patients' privacy and dignity were respected.

Patients said that their care and welfare needs were being met well.

We saw that psychological, occupational and vocational therapy was encouraged to form an important part of patients' treatment plans.

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Summary of findings

Are services responsive to people's needs?

Both patients and staff spoke about a lack of beds in low secure units. The term 'bottle neck' was used frequently.

Patients' diversity, values and human rights were respected.

We saw that multi-agency working happened in line with people's specific needs and forensic history.

The provider took account of complaints and comments to improve the service. The improvements needed to meals is in progress but not yet completed.

Are services well-led?

Improved local governance arrangements were still being embedded so they were meaningful to staff. There were a range of measures in place including the audit processes, meetings relating to governance processes and improvement plans.

Patients were being involved in making decisions about their care and treatment through discussions with staff and their attendance at ward rounds, community meetings and service user forums.

Staff spoke positively about communication on the wards/units and how clinical team leaders worked well with them to encourage team working. Some staff confirmed that they had attended 'Listening in Action' events organised by the trust. However, some staff voiced their concerns about communication with senior management and the trust's board.

Therapists spoke about a lack of access to other senior staff with the same professional backgrounds in other parts of the trust to think about their roles and how best to use their skills for the benefit of patients. They added that there was no central base at Langdon Hospital to allow for exchanging ideas, reflection and research with fellow colleagues.

Staff felt that leadership at ward level was good.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

Patients were legally detained under the Mental Health Act 1983. All treatment had been given under an appropriate legal authority.

Robust arrangements were in place to ensure that leave under section 17 of the Mental Health Act was appropriate and authorised.

Patients were informed of their rights under the Mental Health Act 1983 and were supported in exercising those rights.

A framework for monitoring the provider's duties under the Mental Health Act 1983 was in place. Comprehensive audits were completed on a six-monthly basis. Areas for improvement were identified along with actions to remedy these.

Long stay/forensic/secure services

We found patients were well supported by the staff working at Langdon Hospital. Patients' privacy, dignity, diversity, values and human rights were respected.

Staff encouraged patients to be at the heart of planning their care and treatment. We found comprehensive care plans and risk assessments which considered patients' physical, psychological, emotional and social wellbeing.

Records were completed for incidents of seclusion but there was no seclusion log or register and so it was not possible to check that all incidents of seclusion had been recorded appropriately. Incidents of seclusion are reviewed locally by Ward Managers and Senior Nurses both at team and directorate level. The current recording does not ensure all the necessary details are available to enable effective monitoring of trends on a trust wide level.

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Improved local governance arrangements were still being embedded so they were meaningful to staff. There were a range of measures in place including the audit processes, meetings relating to governance processes and improvement plans.

Summary of findings

What people who use the location say

We did not access surveys at this location but we did speak to people using services and have reported on what people told us during our inspection in the section below.

Areas for improvement

Action the provider MUST take to improve

- The use of seclusion and restraint must be correctly recognised and recorded to ensure its use is effectively monitored.
- The use of governance processes to improve services in the hospital must be embedded further so that staff working in the secure services fully understand their purpose and the actions needed.
- The plans to improve the food for people using the service must be fully implemented.

Action the provider SHOULD take to improve

- Single-use equipment for administering medication should only be used once.
- People should have a copy of their care plan.
- Lead staff roles should be reviewed so that all staff feel supported and able to exchange ideas, reflection and research with fellow colleagues.
- There are excellent facilities available for patients to use as part of their recovery, such as a gym and workshops, but the use of these could be further improved.
- 'Listening in Action' should progress and connect to staff teams that are less engaged with the work of the trust.

Action the provider COULD take to improve

- Safeguarding training could be improved so that it is relevant to experiences on each ward/unit.
- Easy read posters and booklets that are available to patients on the medium secure wards could be improved.

Good practice

Our inspection team highlighted the following areas of good practice:

- We found that patients were well supported by the staff working at Langdon Hospital.
- Patients' privacy, dignity, diversity, values and human rights were respected.
- Staff encouraged patients to be at the heart of planning their care and treatment. We found evidence of comprehensive care plans and risk assessments which considered patients' physical, psychological, emotional and social wellbeing.
- We saw comprehensive involvement of health and social care professionals in patients' care.
- Patients were informed of their rights under the Mental Health Act 1983 and were supported in exercising those rights.

Langdon Hospital

Detailed findings

Services we looked at:
Mental Health Act responsibilities; Long stay/forensic/secure services

Our inspection team

Our inspection team was led by:

Chair: Professor Tim Kendall, Medical Director, Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Jane Ray, Care Quality Commission

Our inspection team at Langdon Hospital was led by a CQC inspector and included an Expert by Experience, a Mental Health Act commissioner, a consultant psychiatrist, a specialist nurse, a specialist social worker and a specialist psychologist.

Background to Langdon Hospital

Langdon Hospital is an NHS forensic Hospital based in Dawlish in Devon and run by Devon Partnership NHS Trust. Devon Partnership NHS Trust which is a Mental Health and Learning Disability trust was established in 2001 and has six hospital sites across Devon and Torbay. The trust employs approximately 2,500 staff and also has 100 staff assigned from Devon County Council and Torbay Unitary Authority, including social workers and support workers. Devon Partnership Trust serves a large geographical area with a population of more than 890,000 people and has an annual budget of around £130 million. The trust services fall into three areas of care:

Mental Wellbeing and Access – for people experiencing a common mental health problem for the first time who need more help than their GP can provide.

Recovery and Independent Living – for people with longer-term and more complex needs.

Urgent and Inpatient Care – for people with severe mental health difficulties, in crisis or experiencing distress and who may require a stay in hospital.

At any one time, the trust provides care for around 19,000 people in Devon and Torbay. The vast majority of these people receive care and treatment in the community. A small number may need a short spell of hospital care to support their recovery if they become very unwell and an even smaller number will have severe and enduring needs that require long-term care. Teams include psychiatrists, psychologists, specialist nurses, social workers, physiotherapists, occupational therapists and support workers.

We inspected the Dewnans Centre which has four medium secure wards with a total of 60 beds. The four wards are Ashcombe, Holcombe, Warren and Cofton. The Dewnans Centre support people on a treatment pathway from acute forensic emergency admissions through to longer-term medium secure services and step down care as people's health and wellbeing improves. Ashcombe is an admissions assessment ward providing care to people with acute mental health conditions. Holcombe Ward is a treatment ward for people with complex mental health needs, including people with personality disorders. Warren

and Cofton provide services to people whose mental health is stable with the care and treatment provided by the hospital. People can and have moved to low secure services from these wards.

We visited Avon House, a 14 bed longer stay low secure ward; Chichester House, a 15 bed shorter stay low secure ward; Owen House, a 16 bed open ward for men with complex mental health needs and Connelly house, a six bed rehabilitation unit.

Our inspection team included a CQC inspector, an Expert by Experience, a Mental Health Act commissioner, a consultant psychiatrist, a specialist nurse, a specialist social worker and a specialist psychologist.

An inspection carried out in September 2013 found breaches in a number of Health and Social Care Act regulations, which led to compliance actions as follows:

The provider did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The planning and delivery of care did not meet service user's individual needs. Some care plans had not involved service users and others had not been reviewed since they were commenced. The provider could not ensure the welfare and safety of service users because staff did not have access to up to date or individualised care plans. Care plans did not reflect published research evidence and guidance on best practice care interventions.

Service users' were not protected from the risks of inadequate nutrition because a choice of suitable nutritious food was not available in sufficient quantities to meet their needs. Service users with special diets did not have a sufficient choice of meals.

Service users, staff and visitors were not protected against the risks of unsafe or unsuitable premises because there were inadequate maintenance and operation of premises on at least three of the hospital wards.

There were not always enough qualified, skilled and experienced staff present on each of the wards to meet people's needs.

The provider did not have consistent systems in place to regularly assess and monitor the quality of the service that service users received because not all risks had been identified and managed. Some complaints had not been responded to within an appropriate time frame and complaints regarding food quality had not been addressed. Not all necessary changes had been made to treatment or care provided. Some care plans had not been reviewed or updated.

The trust provided the Care Quality Commission with an action plan setting out how they were going to attend to the concerns within specific timescales.

Why we carried out this inspection

We inspected this provider as part of our in-depth mental health inspection programme. One reason for choosing this provider is because they are a trust that has applied to Monitor to have Foundation Trust status. Our assessment of the quality and safety of their services will inform this process.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations and local people to share what they knew about the mental health services provided by the Trust. We carried out an announced inspection to Langdon Hospital on 4, 5 and 6 February 2014. During our visit we spoke with over 90 staff, which included nurses, support workers, doctors, occupational and psychological therapists, social workers, advocates, Mental Health Act administrators and members of the management team. We talked with over 40 patients who used services and looked at 42 patient records. We observed various meetings which included patients and staff, for example a patient community meeting. We reviewed other documentation which included, organisational policies, audits, meeting minutes and action plans.

To get to the heart of people who use services' experiences of care, 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?

Detailed findings

- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Mental Health Act responsibilities.
- Acute admission wards.
- Psychiatric intensive care units and health-based places of safety.
- Long stay/forensic/secure services.
- Child and adolescent mental health services.
- Services for older people.
- Services for people with learning disabilities or autism.
- Adult community-based services.
- Community-based crisis services.
- Specialist eating disorder services.
- Other specialist services inspected.

Mental Health Act responsibilities

Information about the service

Langdon Hospital is an NHS forensic Hospital based in Dawlish in Devon and run by Devon Partnership NHS Trust. All of the patients are detained under the Mental Health Act 1983. The trust has a team who monitor the trusts adherence to the Act.

Summary of findings

Patients were legally detained under the Mental Health Act 1983. All treatment had been given under an appropriate legal authority.

Robust arrangements were in place to ensure that leave under section 17 of the Mental Health Act was appropriate and authorised.

Patients were informed of their rights under the Mental Health Act 1983 and were supported in exercising those rights.

A framework for monitoring the provider's duties under the Mental Health Act 1983 was in place. Comprehensive audits were completed on a six-monthly basis. Areas for improvement were identified along with actions to remedy these.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

We reviewed the case records for ten patients selected from Ashcombe, Cofton, Avon and Owen wards. All patients were detained under the Mental Health Act 1983.

We saw that physical health assessments had been carried out and reviewed for all patients. Where appropriate physical health needs were addressed as part of the patient's care plan.

All patients were registered with a general practitioner at the local health centre. Staff told us they received good support from the health practice to help meet patient's physical health needs. For example one patient attended the health practice for the regular bloods tests needed to monitor the impact of his medication as he preferred to have the tests there rather than the hospital. Staff also told us they had effective working relationships with the local general hospital. If patients were taken to the general hospital a member of staff would escort them along with important information that related to the patients current health, allergy advice and current medications. This meant the receiving care staff could provide prompt treatment for any physical health needs.

Robust arrangements were in place to ensure only appropriate and authorised leave was in place. A standardised system was used to authorise and record leave of absence under section 17 of the Mental Health Act. Case records demonstrated that leave was appropriately recorded and included specified conditions where appropriate. However it was not clear from the records whether patients had signed and been given a copy of the leave form. The provider was aware of this and is implementing a system to improve this.

Risk assessments were consistently completed for patients. Case records we looked at demonstrated that comprehensive risk assessments were completed, regularly reviewed and updated when needs or risks changed. These assessments were reflected in the care plans with measures identified to manage or mitigate the risks.

Improvements had been made to the environment in the Dewnams Centre seclusion facilities since our last visit. A mirror had been fitted to ensure that staff were able to observe patients at all times. Ligature risks were present in the seclusion environment in Avon House. Staff were aware of this and had identified these as part of their ligature audit and staff knew how to manage this risk.

Are Mental Health Act responsibilities effective?
(for example, treatment is effective)

We reviewed ten patient records selected from Ashcombe, Cofton, Avon and Owen wards. All patients were legally detained under the Mental Health Act 1983. All detention papers were available for inspection on the provider's electronic information system and demonstrated that renewals of detention had been undertaken with regard to the provisions of the Mental Health Act 1983.

All treatment had been given under an appropriate legal authority for the patients whose case records we reviewed. Criteria used to administer urgent treatment (section 62 of the Mental Health Act) were recorded and met. Requests for a review by a second opinion appointed doctor (SOAD) had been made where appropriate. Since our last visit the provider had implemented a system to ensure that where the patient's medication was consistently authorised on a certificate of second opinion (form T3), there was a record of the discussion between the SOAD and the statutory consultees.

Records where in place of the discussions about consent between the approved clinician and the patient, and the patient's capacity to consent had been recorded at the most recent authorisation of treatment in all the case records examined. A specific capacity assessment to make a decision about treatment had also been completed for each patient.

Are Mental Health Act responsibilities caring?

Patients were informed of their rights under the Mental Health Act 1983 and were supported in exercising those rights. Independent mental health advocates (IMHAs) were available and information was displayed throughout the hospital for patients on how to access an advocate. Case records demonstrated that patients were regularly

Mental Health Act responsibilities

reminded of their rights by staff. Advocates told us that staff were consistently good at ensuring patients were informed of their rights and supporting them in exercising those rights. Patients we spoke with were aware of their rights.

Improvements had been made in care planning since our last visit. Care plans were comprehensive and specific to the needs of the patient concerned. Patients had been involved in their development and care plans included direct quotes from patients regarding their care. Patients told us they were involved in making decisions about their care. This was an area where the hospital is now meeting the requirements of the regulations.

Care plans considered interventions that could be used prior to restraint. Patient's wishes with regard to how their challenging behaviour was managed were sought and reflected where appropriate in care plans. Staff were trained in restraint including any agency staff used in the hospital.

We visited the seclusion facilities in the Dewnams Centre, Avon House and Chichester House. All were adequately furnished with appropriate furniture and access to toilet facilities. They could be ventilated and heated and had a button to call for the attention of staff. Patients in seclusion had access to food and water, and staff to talk to.

Improvements had been made to the environment in the Dewnams Centre seclusion facilities since our last visit. A mirror had been fitted to ensure that staff were able to observe patients at all times. Ligature risks were present in the seclusion environment in Avon House. Staff were aware of this and had identified these as part of their ligature audit and knew how to manage the risk.

We reviewed a sample of seven seclusion records. Seclusion records were completed for individual incidents of seclusion but there was no seclusion log or register and so it was not possible to check that all incidents of seclusion had been recorded appropriately. The reviews of seclusion required by the Code of Practice were mostly completed in the individual patient's records. Any errors identified in the recording were addressed by the lead consultant and nurse following the seclusion episode. However there were some delays in patients in seclusion being reviewed by a doctor. Staff told us this was due to their only being one doctor on call for the Langdon Hospital and inpatient facilities in Exeter outside of office hours.

Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain disturbed behaviour which is likely to cause harm to others. Seclusion is not a planned treatment technique and should not be used as a part of any planned treatment programme. It should only ever be used as a last resort. We found incidents of patients being nursed in, and prevented from leaving, the extra care areas of Avon House and Chichester House. These had not been recorded as seclusion episodes by staff and there was a lack of clarity from some staff as to the definition of seclusion. This meant that at times, staff were adopting restrictive practice measures to manage a patient's emotional distress and were not adhering to the safeguards required by the Mental Health Act, Code of Practice.

Are Mental Health Act responsibilities responsive to people's needs?

(for example, to feedback?)

The provider monitored the amount of leave authorised under section 17 of the Mental Health Act against the amount of cancelled leave, along with the reasons for this. This showed that for the period 26 December 2013 to 26 January 2014 there were 1,360 episodes of leave authorised. Of these 91 episodes were cancelled, 59 of these due to patient choice, 10 due to clinical reasons, 18 due to staffing availability and four due to the visitor or destination being unable to provide the leave. Staff told us that wherever possible alternative leave arrangements were made when staff were not available at the agreed time.

Both patients and staff spoke about a lack of beds on low security wards. Patients and staff spoke about feeling frustrated by the situation due to some patients, currently residing in medium secure facilities, being ready for low secure care and therefore being inappropriately placed. This meant that individual patients' recovery was, in effect, 'put on hold' and were subject to the same restrictions as those requiring medium secure care.

Care plans were re-evaluated and updated regularly. Plans to discharge the patient or move towards less secure environments were included as part of the care planning process.

Mental Health Act responsibilities

Patients were involved in the day to day running and development of the ward through regular patient forums and meetings.

Are Mental Health Act responsibilities well-led?

A framework for monitoring the provider's duties under the Mental Health Act 1983 was in place at the hospital. Comprehensive audits were completed by the Mental Health Act administrator on a six monthly basis. These included audits of consent to treatment, information on rights for patients and their families and section 17 leave. Areas for improvement were identified along with actions to remedy these. Reminders were issued for relevant staff to ensure the provider's duties under the Mental Health Act were met. Training was provided as needed on the wards by the Mental Health Act administrator. A clear process was in place to scrutinise Mental Health Act statutory paperwork to avoid unlawful detentions.

We spoke with the manager with lead responsibility for Mental Health Act administration at the trust. She confirmed that the trust has a governance process in place for looking at the use of the Mental Health Act. Inpatient audits undertaken at hospital level are aggregated and presented at the hospital managers meeting along with information about how frequently different sections of the Mental Health Act are used. Through this meeting the hospital managers also look at any findings from CQC and other external reviews about how the Mental Health Act is operated. Any areas of concern found are referred to the trust's quality and safety group and to directorate management groups for taking forward at hospital level.

Long stay/forensic/secure services

Information about the service

Langdon Hospital is an NHS forensic Hospital based in Dawlish in Devon and run by Devon Partnership NHS Trust. The site consists of the Dewnans Centre which has four medium secure wards with a total of 60 beds. The four wards are Ashcombe, Holcombe, Warren and Cofton. The Dewnans Centre support people on a treatment pathway from acute forensic emergency admissions through to longer term medium secure services and step down care as people's health and wellbeing improves. Ashcombe is an admissions assessment ward providing care to people with acute mental health conditions. Holcombe Ward is a treatment ward for people with complex mental health needs, including people with personality disorders. Warren and Cofton provide services to people whose mental health is stable with the care and treatment provided by the hospital. People can and have moved to low secure services from these wards. The site also has Avon House, a 14 bed longer stay low secure ward; Chichester House, a 15 bed shorter stay low secure ward; Owen House, a 16 bed open ward for men with complex mental health needs and Connelly house, a six bed rehabilitation unit.

Summary of findings

Staff encouraged patients to be at the heart of planning their care and treatment. We found comprehensive care plans and risk assessments which considered patients' physical, psychological, emotional and social wellbeing.

We found patients were well supported by the staff working at Langdon Hospital. Patients' privacy, dignity, diversity, values and human rights were respected.

Improvements had been made to the seclusion facilities in the Dewnans Centre since our last visit. Improvements were needed in the seclusion environments in Avon House.

Records were completed for incidents of seclusion but there was no seclusion log or register and so it was not possible to check that all incidents of seclusion had been recorded appropriately. Incidents of seclusion are reviewed locally by Ward Managers and Senior Nurses both at team and directorate level. The current recording does not ensure all the necessary details are available to enable effective monitoring of trends on a trust wide level.

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Staff found it hard to describe clearly the areas for improvement and action taking place at Langdon Hospital. There were a range of governance measures in place including the audit processes, meetings relating to governance processes and improvement plans, but these need to become embedded so they are meaningful to staff working in the hospital.

Long stay/forensic/secure services

Are long stay/forensic/secure services safe?

Learning from incidents

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. We looked at the incident records and we saw that actions had been taken in line with the organisations policies and procedures. Where patient incidents had taken place we saw involvement of other health and social care professionals and where necessary a patient being transferred to more appropriate facilities, such as a different ward or return to prison. There was also a review to ensure the mix of people living together was safe.

Safeguarding

Patients we saw and spoke with confirmed that they felt safe and supported by staff at Langdon Hospital and had no concerns about the ability of staff to respond to safeguarding concerns. They felt that their human rights were upheld and respected by staff. Comments included: "I feel safe here and know I could raise any concerns with staff" and "I would not have a problem raising concerns if I had any."

We spoke with staff about their understanding of what constituted abuse and how to raise concerns. They demonstrated a good understanding of what might constitute abuse and knew where they should go to report any concerns they had. Staff informed us that they had received formal safeguarding training. The provider may find it useful to note that staff felt that face to face safeguarding training relevant to experiences on their actual ward/unit would be beneficial.

The provider responded appropriately to any allegation of abuse. We saw copies of both the multi-agency policy and procedures for safeguarding adults and children. They set out the measures which should be in place to safeguard vulnerable adults, such as working in partnership with the local authority. We saw that wards had a 'safeguarding adults' flowchart visible in the staff office, which broke down the actions to be taken if an alleged safeguarding concern had been identified. It was easy to follow which enabled staff to be clear about their responsibilities, such as informing the nurse in charge, the unit's management team, liaising with the local authority and the completion of an incident form. We also saw that patients on the low secure units had access to easy read posters and booklets to raise awareness of abuse and the process which should be followed if abuse was suspected. Staff informed us that patients did take and read the booklets. We did not see evidence of easy read posters and booklets available to patients on the medium secure wards.

Safe Environment

We toured the eight wards and units which made up the Langdon Hospital site. Annual ligature audits had been conducted to assess each ward/units safety and to identify areas of risk. We saw that these had been conducted in 2013 and showed the measures put in place to mitigate the risk to patients. At our previous inspection in September 2013, we found that some windows could be a potential ligature risk because of the metal brackets in place when the windows were open. We were told and we saw that the windows had now been fitted with appropriate mechanisms to attend to the ligature risk. This was an area where the hospital is now meeting the requirements of the regulations.

Ligature risks were present in the seclusion environment in Avon House. These safety issues were being addressed.

As we toured the bedroom corridors in the Dewnans Centre staff told us they were concerned about not having a clear line of sight especially at night. Whilst there is CCTV available, the positioning of staff within the unit at night facilitates the monitoring of corridors and access to patients bedrooms. We were informed and saw that observations were undertaken by staff, which means walking around the ward, checking where patients are. We spoke to members of the management team, who stated that a green light came on in the staff office when a patient came out of their bedroom and the corridor lights came on to alert staff.

There were good security measures in place. For example, upon arrival at the hospital we were asked to show our identity badges and to sign in and on leaving we had to sign out. The new medium secure hospital building had a double door entry and exit system where one door could only be opened once the other door had been secured (known as an 'airlock'). We found all of the wards at the hospital had good security measures in place to ensure that they knew who entered and who left the buildings. We were also shown a current audit for airlock access to

ensure security procedures were being followed. This demonstrated that staff recognised the importance of ensuring patients, staff and visitors safety when visiting the hospital.

At our previous inspection in September 2013, a registered nurse on duty highlighted that the seclusion suite did not have a mirror in situ which meant there was a blind spot. At this time, the lead nurse said that this would be rectified as a priority. We toured the seclusion suite and found that a mirror had been installed to attend to the concerns raised. This demonstrated that the organisation attended to arising issues in a timely way to ensure patients and staff safety.

Risk Management and Managing risk to the person

Care and treatment was planned and delivered in a way that ensured patients safety and welfare. We saw evidence of detailed, person centred care plans specific to individual needs. Care plans included the assessment and management of risk. For example increased observation levels due to concerns over a patient's safety and welfare and the use of de-escalation techniques to help manage a patient's emotional distress. This demonstrated the importance of providing care and support to patients in a holistic and less restrictive way.

Medication

We looked at elements of medicines management across the hospital site. We saw that appropriate arrangements were in place for the obtaining, recording, handling, using, safekeeping, safe dispensing, safe administration and disposal of medicines. We were informed that stable doors were due to be installed in clinic rooms due to incidents of patients grabbing medication from the trolleys when nurses were administering medicines. Measures had been put in place, whilst awaiting the new doors. We found one ward where a single use syringe plunger had been re-used. We spoke to a member of the management team and the medicines lead and looked at the stock level of syringe plungers. We found the stock level of plungers was very low and if they were being used singly the ward would have run out. We were told that a new supply of plungers were due to be delivered. We witnessed the member of the management team ask the medicines lead to compile a protocol for staff to adhere to whilst we were in the clinic room.

Safe staffing levels

Staffing levels varied across the wards/units according to patient's needs. On the whole, patients and staff felt there were sufficient staffing levels. Staffing levels had been increased on certain wards due to the complex needs of patients since the last Care Quality Commission inspection in September 2013. This was an area where the hospital is now meeting the requirements of the regulations.

The management team explained that they had current challenges with the recruitment and retention of staff, especially registered nurses. We were told the organisation was actively recruiting and as part of this had widened their recruitment drive to Manchester, London and Dublin. The interim measures included the use of an agency called NHS Professionals, which had been developed by the Department of Health to provide flexible staffing solutions for organisations by having a pool of staff with relevant skills, knowledge and professional experience in order to meet the varying needs of patients within different settings. A contract had been agreed with this agency to provide staff consistently at Langdon Hospital. These staff members received the same level of training as those employed by the organisation to ensure consistent skills across the site. This demonstrated the organisation was ensuring that staffing levels remained stable with the use of outside agencies, at the same time making sure they had appropriately qualified and competent people covering the staff shortages to attend to patient's needs.

Langdon Hospital was piloting a senior nurse being on duty at night to provide support to staff. Also consultant psychiatrists were now working seven days a week between 9am and 5pm. Outside of these hours, a consultant psychiatrist was on call. Medical cover at night was provided by a junior doctor based in Exeter. Langdon Hospital did not have dedicated junior doctor night cover, which posed issues at night when medical support was needed. Medical support at night remained a problem, especially when a patient needed to be reviewed in seclusion in a timely way in line with policies and procedures.

Long stay/forensic/secure services

Are long stay/forensic/secure services effective?
(for example, treatment is effective)

Use of clinical guidance and standards
We saw that Langdon Hospital adopted the 'my shared pathway'. My Shared Pathway evolved as part of the Secure Services Quality Improvement Productivity and Prevention (QIPP) Programme, it is one of three initiatives that have been developed to reduce lengths of stay in secure care. My Shared Pathway is about providing a recovery and outcomes based approach to the care pathway. We saw evidence that care planning and risk management was in line with this approach. This demonstrated that Langdon Hospital and the wider organisation recognised that recovery focused service provision was key to people's future wellbeing.

We saw that clinical guidance and standards were implemented, such as that of the National Institute for Health and Care Excellence. We reviewed policies and procedures, observed clinical practice and multidisciplinary discussions which were in line with best practice guidance and the Mental Health Act Code of Practice.

Monitoring quality of care
Langdon Hospital participates in the Quality Network for Forensic Health Services, a peer review scheme operated by the Royal College of Psychiatrists and helps to monitor the quality of services provided.

In addition there is a programme of local audits. We saw that Langdon Hospital had effectively implemented a care plan audit which helped flag up gaps and lack of detailed and comprehensive plans of care and risk assessments. Care plan audits were followed up as part of staff supervision so that continued professional learning and development could be attended to.

We saw that other audits were in place, such as infection control and medicines management. These were conducted on each ward on an ongoing basis to monitor the quality and safety of service provision.

We saw that handovers between shifts were comprehensive and detailed and had improved since our last inspection in September 2013. A handover form had been implemented to ensure staff covered all areas so that staff coming on shift were fully informed of events on the wards.

Collaborative multi-disciplinary and multi-agency working for assessments, care planning and access to health services
We saw comprehensive involvement of health and social care professionals in patient's care. Each ward/unit had a dedicated team of professionals, including nurses, doctors, psychologist and occupational therapist who worked consistently with patients on specific wards. This enabled the development of therapeutic relationships and continuity of care provision.

We also saw that primary care services visited Langdon Hospital on a weekly basis. Professionals included a GP and practice nurse. This enabled physical health issues to be addressed in a timely way. Langdon Hospital also had a dentist service on site so that people's dental needs could be attended to.

We observed multi-disciplinary reviews taking place. For example, a group of professionals gathered together to discuss a particular patient's diagnosis and how best to support them to aid their recovery. This demonstrated that professionals of different disciplines strongly felt that working together was important, so patients received the right care and support.

Are staff suitably qualified and competent
Patients we spoke with said that staff were supportive and helpful. Staff knew how to respond to specific health and social care needs and were observed to be competent. Staff were able to speak confidently about the care practices they delivered and understood how they contributed to patients' health and wellbeing.

Staff confirmed that they received training on an ongoing basis enabling them to carry out their roles confidently. We saw that staff received training on safeguarding vulnerable adults and children, fire safety, infection control, diversity, information governance, moving and handling, conflict resolution, basic life support and first aid, physical intervention and breakaway techniques. This showed that care was taken to ensure that staff were trained to a level to meet patients' current and changing needs.

We saw that Langdon Hospital employed newly qualified nurses who were encouraged by the organisation. As part

of their new role they received a preceptorship, requiring them to work closely with their mentors and experienced registered nurses to ensure they developed both their competence and confidence in working in an inpatient mental health unit. Additionally, the preceptorship enabled the identification of areas to work on as part of their ongoing professional development.

Staff received regular supervision and appraisals in order for them to feel supported in their roles and to identify future professional development training needs.

This demonstrated that the organisation recognised the importance of having a staff team which were well trained and supported in order to meet the needs of the patients staying at Langdon Hospital.

Are long stay/forensic/secure services caring?

Choice in decisions and participation in reviews

Patients who used the service understood the care and treatment choices available to them. Patients told us how they were helped to understand care and treatment choices. Comments included: "I had a chance to talk about what I want to achieve", "when you've got problems they (the staff) care", "staff and doctors listen to me more than I thought they would," and "this place has got the right medication for me. I do cooking, sport, English and maths – the occupational therapist has helped. The doctor is a good bloke."

We saw evidence of patients being involved in making decisions about their care and treatment through discussions with staff and through their attendance at ward rounds, service user forums and community meetings. We observed staff spending time with patients, supporting them to make future decisions about their care and treatment. Care records showed that patients had one to one sessions with staff to discuss their current mental and physical health and to decide on future plans following discharge, such as accommodation and relationships with others.

We saw evidence of advocacy involvement in patients care and spoke with one of the advocates about the service they offered patients. They explained that they supported patients with ward rounds (this is the process where a group of health and social care professionals meet with each patient to plan future treatments).The advocate's role was to support patients to ensure they were represented and enabled to understand what was being said in the ward round.

Patients informed us that they were involved in the planning of their care and support. This was achieved through care plans being developed with patients' involvement, so they were empowered to be in charge of their own care and treatment. Not all patients stated that they had copies of their current care plans. The sharing of care plans enabled patients to refer to them at times of distress or when they need to clarify certain points so they could contribute to future care planning.

Patients were supported in promoting their independence and elements of community involvement dependent on individual circumstances. We saw that psychological, occupational and vocational therapy were encouraged to aid patients overall wellbeing and recovery. The medium secure unit had a therapies corridor, which included a workshop and education room. Throughout our inspection we saw that this resource could have been made more use of. We saw patients accessing the local community, either visiting the medium secure unit's coffee shop or going to the shops with staff support. We saw that patients detained under the Mental Health Act were encouraged, when appropriate, to access the local community to aid their recovery.

Effective communication with staff

We observed staff communicate with patients in a respectful way. We saw staff spending time with patients talking about a range of subjects of interest and looking through the newspaper, to enable patients to remain up to date with current affairs. On one occasion, a patient became distressed and we saw staff professionally work with the individual by spending one to one time with them and using de-escalation techniques. This demonstrated that staff recognised effective communication to be an important way of supporting people and aid the development of therapeutic relationships.

Do people get the support they need

Patients said their care and welfare needs were being well met. Comments included: "the staff are very kind, very caring" and "I feel supported and feel safe on the ward." We observed patients and staff, seeing plenty of positive interactions taking place and patients looked relaxed and comfortable asking staff for advice or information.

Long stay/forensic/secure services

Recovery services

We saw that psychological, occupational and vocational therapy was encouraged to form an important part of patients' treatment plans. Activities were varied and included arts and crafts, cooking, exercises, coping strategies, psychological wellbeing and a range of psychological therapies including cognitive behavioural therapy and motivational interviewing.

We saw that a 'Discovery Centre' on site enabled patients to engage in a range of courses, including tai chi. The hospital site also had a café called 'Oasis', which was run by patients from both the medium and low secure wards/ units. This demonstrated that recovery focused activities and therapies were an integral part of patients care and treatment plans.

Privacy and Dignity

Patients' privacy and dignity were respected. We toured each ward/unit and found that patients had their own ensuite bedroom. Patients felt that their privacy and dignity were respected by staff.

Restraint and Seclusion

We saw that restraint was used on occasions for the safety of a patient and that of others. We saw evidence this was only used as a last resort when all other interventions and de-escalation techniques, such as one to one talking time with staff, had been exhausted. Where we saw evidence of restraint being used there was documented evidence of other interventions being tried first and of nursing staff seeking the advice of other health care professionals. Staff confirmed that they had received training to ensure they were knowledgeable about the principles of restraint and were competent and confident, when carrying out these interventions, safeguarding patients from harm. Training records confirmed this. The management team explained that at all times, the wards were staffed with sufficient staff numbers to carry out restraint safely and emphasised the importance of their staff team having the appropriate training to practice safely.

There were arrangements in place to deal with foreseeable emergencies. Where we saw medicines used to manage a person's behaviour the correct policies and procedures were followed. We saw evidence of alternatives being offered before moving to rapid tranquilisation. Rapid tranquilisation is used when disturbed or violent behaviour by an individual in an adult in-patient psychiatric setting poses a serious risk to that individual, other patients and staff.

Langdon Hospital followed the organisation's rapid tranquilisation policy. This guidance was in line with the National Institute for Health and Care Excellence (NICE) for the short term management of disturbed/violent behaviour in in-patient settings. It covered the importance of appropriate medication choices for rapid tranquilisation; how to monitor the patient following the use of medication; staff training requirements and administering medication within the legal limits of the Mental Health Act.

We toured the seclusion facilities and saw that most conformed with the Mental Health Act Code of Practice. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain disturbed behaviour which is likely to cause harm to others. Seclusion is not a planned treatment technique and should not be used as a part of any planned treatment programme. It should only ever be used as a last resort. Ligature risks were present in the seclusion environment in Avon House. This meant that these facilities did not conform with the Mental Health Act Code of Practice. The need for these environments to be safe was being managed and addressed.

We looked at the seclusion records and saw that they were not being completed in line with the organisation's policy and clinical guidance and standards. Also, where medical reviews were due, we found that at times these were late or gaps were evident in records, which would demonstrate that reviews had taken place. Staff voiced concern about the lack of on-site medical support available at night to review people in seclusion, with a doctor having to travel from Exeter.

In one patients clinical records the observation charts referred to that individual being asleep. However, there was no indication of how the staff knew the patient was actually sleeping. One entry stated 'lying face down on mattress, presenting as asleep.' It was not recorded if the patient was breathing audibly or if their chest was moving. These concerns were also raised at our inspection in September 2013 where the manager and Senior Nurse Manager said

this would be rectified. This demonstrated that efforts to ensure records were completed in line with policies and guidance were still not always being adhered to by staff working at Langdon Hospital.

We asked for a review of incidents run from the electronic system which had taken place since our visit in September 2013. We looked at this information alongside paper seclusion records. We found that the print out did not correlate with paper records, with paper records showing that more seclusions had taken place during this period. This posed a risk that inaccurate information will reduce the effectiveness of the monitoring arrangements. We spoke to members of the management team about this and they explained that it had been identified that staff were not coding incidents properly. We saw this issue had been identified at an 'adverse incident review group' meeting in June 2013. The outcome being that clinical team leaders should be reviewing codes and encouraging consistent coding from their teams. A 'how to code your incident' document was also cascaded to teams following this meeting. We were told that whilst due to human factors errors still occur this is picked up with the individuals concerned.

We also found extra care areas were available when patients were feeling distressed. We asked staff how these were managed and whether patients were free to leave at any stage. Staff explained that at times the door would be locked to prevent a patient leaving due to their behaviour. We asked staff about the Mental Health Act Code of Practice and their understanding of what constituted seclusion. Staff did not recognise that preventing a patient from leaving an extra care area was in fact seclusion. This meant that at times, staff were adopting restrictive practice measures to manage a patient's emotional distress and were not adhering to the safeguards required by the Mental Health Act Code of Practice.

Are long stay/forensic/secure services responsive to people's needs?
(for example, to feedback?)

Service meeting the needs of the local community
Both patients and staff spoke about a lack of available beds in low secure units. The term 'bottle neck' was used frequently. We established that on the whole patients were not discharged directly into the community from medium secure and that a 'step down' approach was adopted. Patients and staff spoke about feeling frustrated by the situation due to some patients currently residing in medium secure facilities being ready for a low secure service and therefore being inappropriately placed. This meant that individual patients' recovery was, in effect, 'put on hold'.

We also established that there were no secure service facilities for women in Devon, which meant that they had to be placed out of county. This meant that family and carers would have to travel further to see their relative which could impact on the patient's mental health recovery.

Work of the trust reflects Equality, Diversity and Human Rights
Patients' diversity, values and human rights were respected. We saw Langdon Hospital had a reflections room, which provided a multi-faith area for patients to use. We were told that patients accessed the room in order to attend to their spiritual needs and enable them time for reflection and quietness. However, for some individuals, access to this service was limited to when staff were available to support them attending.

Patients' human rights were respected. This was through care and support being person centred and the correct use of the Mental Health Act. We saw evidence of independent mental health advocates (IMHA's) involvement showing Langdon Hospital recognised the importance of patients having their human rights upheld through them being able to access independent advice when needed.

Providers working together during periods of change
We saw multi-agency working happened in line with people's specific needs and forensic history. We saw that liaison took place with the Ministry of Justice, local authority, the Multi Agency Public Protection Authority (MAPPA), probation and prison service and community mental health teams. Staff and patients commented that communication between providers was good and enabled recovery and rehabilitation methods to be adopted. Care records showed extensive evidence of professionals working together. For example, support following discharge from the secure mental health services.

Learning from complaints
The provider took account of complaints and comments to improve the service. There was evidence that these had

been appropriately followed up by the management team, such as conversations with the complainant, learning outcomes being implemented and additional training for staff being put in place. We saw a copy of the 'complaints, concerns and compliments update' dated January 2014, which outlined the actions which had been and were being taken to resolve complaints. This demonstrated that the organisation valued people's comments to improve the quality of care provided and the overall running of the service.

However, patients commented they had complained about the food provision but nothing had been done to resolve this. We saw displayed on wards minutes from the catering committee dated 28 January 2014. The committee included patient representatives and showed the measures being put in place to resolve the issues with the food, including a move to cook chill. We concluded that steps were being taken to address complaints about food but how these changes were communicated with patients required further work. The compliance action from the previous report will remain open until the new system for meals is implemented and patients have confirmed they are satisfied with the arrangement.

Are long stay/forensic/secure services well-led?

Governance arrangements

We saw evidence of various local audits leading to improvement plans, which were in the process of being implemented. For example, we saw minutes for the 'quality and safety' meeting dated January 2014 and cluster governance meetings for December 2013 and January 2014. When we asked to see further meeting minutes, on several occasions, we were told that there had only been one meeting and that action points were currently being followed up to inform the next meeting. We found that local governance arrangements were being embedded and it was hard to assess how effective they were and the level of follow through. We found the many areas of improvement work appeared complicated and staff voiced confusion about these when speaking about them throughout our inspection. The previous compliance action about assessing and monitoring the quality of the service is ongoing to allow the trust to complete their action plan.

We saw Langdon Hospital's risk register, which clearly outlined areas of concern and the level of risk. These entries reflected the actions that were taking place. This demonstrated the management team recognised risks and took action to mitigate against them increasing.

Engagement with patients

We saw evidence of patients being involved in making decisions about their care and treatment through discussions with staff and through their attendance at ward rounds, community meetings and service user forums. We observed staff spending time with patients, supporting them to make future decisions about their care and treatment. Care records showed that patients had one to one sessions with staff to discuss their current mental and physical health and to decide on future plans following discharge, such as accommodation and relationships with others.

Engagement with staff – ward to board

Staff spoke positively about communication on the wards/units and how clinical team leaders worked well with them and encouraged team working. Some staff confirmed that they had attended 'Listening in Action' events organised by the trust. However staff also voiced their views about communication with senior management and the trust's board. Comments included: "they are disengaged", "there's no coming together", "they don't know what we are doing or what is going on. Listening into Action does not engage well".

We discussed these views with members of the management team. They explained that engagement with staff was paramount in order to support patients effectively and allow for staff to feel part of changes in service provision and the challenges which are faced. In addition, members of the management team were actively seeking opportunities to be more visually present on the wards/units. This would allow them to attend to any issues staff had and to see for themselves the pressures that staff experienced. We saw evidence of staff being encouraged to share new ideas, be part of work streams and become leads for specific areas, such as medicines management. The management team recognised that further work was needed to increase engagement with staff and that this was to be an ongoing process.

Supporting staff with change and challenges

Therapists spoke about a lack of access to other senior staff with the same professional backgrounds in other parts of

the trust to think about their roles and how best to use their skills for the benefit of patients. They added that there was no central base at Langdon Hospital to allow for exchanging ideas, reflection and research with fellow colleagues.

Effective leadership

Staff felt that leadership at ward level was good. We observed this during our visit with tasks being delegated appropriately to staff members. The therapists working at Langdon did however tell us that they did not feel well led and there were no leadership roles available for them. One comment stated “there is a vacuum in therapy.” Therapists felt that no one was really picking up the issues happening in practice.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations** **2010** **Meeting nutritional needs** **How the regulation was not being met:** At Langdon Hospital service users' were not protected from the risks of inadequate nutrition because a choice of suitable nutritious food was not available in sufficient quantities to meet their needs. Service users with special diets did not have a sufficient choice of meals. This was a breach of Regulation 14(1)(a)

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations** **2010** **Meeting nutritional needs** **How the regulation was not being met:** At Langdon Hospital service users' were not protected from the risks of inadequate nutrition because a choice of suitable nutritious food was not available in sufficient quantities to meet their needs. Service users with special diets did not have a sufficient choice of meals. This was a breach of Regulation 14(1)(a)

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations** **2010** **Meeting nutritional needs** **How the regulation was not being met:** At Langdon Hospital service users' were not protected from the risks of inadequate nutrition because a choice of suitable nutritious food was not available in sufficient quantities to meet their needs. Service users with special diets did not have a sufficient choice of meals. This was a breach of Regulation 14(1)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations** **2010** **Assessing and monitoring the quality of service** **How the regulation was not being met:** Service users are not protected from the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services as follows: The use of governance processes at Langdon Hospital are not yet fully embedded so staff fully understand their purpose and the actions that are needed to ensure services are operating effectively. This was a breach of Regulation 10(1)(a)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations** **2010** **Assessing and monitoring the quality of service** **How the regulation was not being met:** Service users are not protected from the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services as follows: The use of governance processes at Langdon Hospital are not yet fully embedded so staff fully understand their purpose and the actions that are needed to ensure services are operating effectively. This was a breach of Regulation 10(1)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations** **2010** **Assessing and monitoring the quality of service** **How the regulation was not being met:** Service users are not protected from the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services as follows: The use of governance processes at Langdon Hospital are not yet fully embedded so staff fully understand their purpose and the actions that are needed to ensure services are operating effectively. This was a breach of Regulation 10(1)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations**

This section is primarily information for the provider

Compliance actions

2010

Safeguarding service users from abuse

How the regulation was not being met:

Seclusion is being used without suitable arrangements in place to protect service users against the risk of such control and restraint being excessive as follows:

The use of seclusion is not being correctly recorded so its use can be monitored.

Other extra care rooms are being used at Langdon Hospital by staff for seclusion without this being recognised as such.

This was a breach of Regulation 11(2)(b)

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations** **2010** **Safeguarding service users from abuse** **How the regulation was not being met:** Seclusion is being used without suitable arrangements in place to protect service users against the risk of such control and restraint being excessive as follows: The use of seclusion is not being correctly recorded so its use can be monitored. Other extra care rooms are being used at Langdon Hospital by staff for seclusion without this being recognised as such. This was a breach of Regulation 11(2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations** **2010**

This section is primarily information for the provider

Compliance actions

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Other extra care rooms are being used at Langdon Hospital by staff for seclusion without this being recognised as such.

This was a breach of Regulation 11(2)(b)