Good

St George Care UK Limited

St Mary's Hospital

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)
1-589161950	St Mary's Hospital	Adams Ward	WA2 8DB
1-589161950	St Mary's Hospital	Dalston Ward	WA2 8DB
1-589161950	St Mary's Hospital	Cavendish Ward	WA2 8DB
1-589161950	St Mary's Hospital	Leo and Hopkins Ward	WA2 8DB

This report describes our judgement of the quality of care provided within this core service by St Mary's Hospital. 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 St Mary's Hospital and these are brought together to inform our overall judgement of St Mary's Hospital.

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	Good
Are services safe?	Good
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 St Mary's Hospital as good because:

- Staff had created clear plans to manage all environmental risks and could identify risks at a ward level. Security systems were in place to maintain the safety of patients and staff.
- The organisation recognised that they used a high number of bank and agency to cover supportive observations, and had begun the process of over recruiting to those posts to ensure there was more consistency in staffing.
- A 'no force first' ethos was evident across the ward, and prone restraint and rapid tranquilisation was not used except in exceptional circumstances.
- Safeguarding procedures were in place and staff were able to tell us how they would identify and report any issues.
- Care plans were comprehensive and holistic; these were written from the patients' perspective. Patients on Leo and Hopkins ward had positive behavioural support plans in place.
- There was a range of psychological therapies available in line with National Institute of and Health Care Excellence guidance.
- The hospital employed a wide range of professionals who all worked effectively as part of the multi-disciplinary team (MDT). The MDT listened to patients and their wishes and concerns and addressed these with the MDT.
- We observed staff being kind and caring with patients, and we found them to be knowledgeable about the patients they cared for.
- Weekly referrals meetings took place that assessed the suitability of all referrals and assessments for admission.
- The hospital had a complaints procedure and this was seen to be followed. The majority of patients felt confident in the complaints system and that changes would be made if things went wrong.
- Patients were able to personalise their bedrooms and have equipment such as televisions and radios in their rooms. A private phone booth was also available for patients to make telephone calls.

However:

- Some staff were not bare below the elbow.
- Fewer than 75% of staff had completed some elements of the mandatory training programme.
- There was no evidence of any additional training to support the specialist patient groups such as acquired brain injury or autistic spectrum conditions that would support staff in their role. Care plans and information available on the wards was not written in a way which was adapted for the reader, and was often lengthy or wordy.
- British sign language interpreters were not used on a day-to-day basis, only for scheduled meeting or appointments.
- The patients commented negatively about the quality and the portion size of the food available.
- The visions and values of the trust were not completely embedded at ward level and supervision for staff was not always in line with the organisation's policy.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All environmental risks had clear plans in place on how these were managed and staff could identify risks at a ward level.
- The clinical rooms were well stocked with emergency equipment available for staff to access.
- Security systems were in place to ensure the safety of patients' and staff.
- The hospital was employing additional staff to ensure there was consistency in patient care.
- There were enough staff to support one to one time, leave and activity which were rarely cancelled due to staff shortages.
- There was evidence of a 'no force first' ethos, and a reduction of incidences on Leo and Hopkins ward.
- Prone restraint and rapid tranquilisation were not used except in exceptional circumstances.
- Good links with pharmacy, and local arrangements were in place for the prescribing, dispensing, transporting and administering medications.
- Staff were aware of how to report incidents, and were debriefed following incidents and had access to counselling and spiritual support.
- A blanket restrictions group was set up to review all restrictions across all the provider's hospitals, which meant that some restrictions had been reduced and others were in the process of being reviewed.
- Safeguarding procedures were in place, with strong links with the local authority.

However:

- Some staff were not adhering to bare below the elbow and were observed to be wearing false nails.
- Mandatory training in Leo and Adams wards fell below 75% in some areas.

Are services effective?

Good

We rated effective as good because:

- Holistic care plans were in place for all patients, including positive behaviour support plans for those patients on Leo and Hopkins ward.
- A general practitioner attended the hospital on a sessional basis to assess patients' physical health care needs.

Summary of findings

- A range of psychological therapies was available within the hospital.
- Rapid tranquilisation was very rarely used and staff understood the impact of high dose medications would potentially have on their patient groups.
- Patient outcomes were measured in a variety of ways and staff were actively involved in clinical audit.
- There was a wide range professionals employed and all worked effectively as part of the multi-disciplinary team.
- Staff we spoke to understood the Mental Health Act and the principles of the Code of Practice that were relevant to their service.
- Staff demonstrated awareness of the MCA and there was a process to follow should they have to make a decision about a person's capacity to consent.

However,

- Care plans were not written in a way in which was meaningful to the patients.
- Additional training in acquired brain injury and autistic spectrum conditions were not available to enhance staffs knowledge and skills.
- Supervision on Leo and Hopkins ward did not happen in line with the organisations policy.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness dignity and respect, Staff that we spoke with, spoke positively about patients and understood their individual needs well.
- The majority of patients and carers we spoke to said that the staff were kind and caring.
- Care plans were written from the patient's perspective and MDTs were patient focused.
- Community meetings took place weekly that gave patients the opportunity to have their say about the ward environment, activities, food and staffing and a patient's forum had also been developed so that patient representatives could take their feedback to the senior managers.

However,

- Some patient told us that staff could use humour, which could be misunderstood, and this could annoy patients.

Summary of findings

- Patients also told us that they did not have a care plan and where they did, it was often written in format that they found difficult to understand.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Information displayed on the wards could be wordy and lengthy which did not meet the needs of the patient group
- Adams ward did not access basic sign language interpreters on a day-to-day basis to meet the everyday communication needs of the deaf population on the ward
- Patients were negative about the food particularly the quality and portion sizes, there were also three complaints about the food and the attitude of kitchen staff.

However,

- A weekly referrals meeting which took place, which assessed the suitability of all referrals and assessments.
- There was a structured programme of activities available, which took place across the hospital. This included access to the local college and amenities.
- The hospital ran a permitted earning scheme, where patients could apply for roles within the hospital and be paid for their services.
- Patients had access to a private pay phone, hot and cold drinks 24 hours a day and were able to personalise their bedroom areas.
- Complaints were dealt with in line with their own policy, and patients told us they knew how to complain and their complaints would be addressed

Are services well-led?

Good

We rated well-led as good because:

- Senior managers and service managers were approachable and had an 'open door' approach.
- There were clear governance systems in place to ensure that, at both ward level and board level, quality and safety were monitored
- The hospital was working towards ensuring consistency of staffing by over recruiting so that they were able to staff longer-term supportive observations of patients.
- Service managers had access to their key performance indicators (KPI) and these were monitored through their supervision.

Summary of findings

- Service managers had enough authority and administrative support to perform their role.
- Staff on Adams ward were commencing the safeward initiative.

However,

- The visions and values of the organisation were not embedded at ward level

Summary of findings

Information about the service

St Mary's Hospital, Warrington provides specialist services for people with acquired brain injury and autistic spectrum conditions. It is part of the St George Healthcare Group, which also has two other locations within the north west.

St Mary's Hospital is a 58 bedded hospital which has 5 wards:

Cavendish ward – 8 bed locked rehabilitation ward for males with an acquired brain injury (ABI), serving as a step down from low secure services.

Adams Ward – 12 bed medium secure ward for men with an ABI with an additional 4 bedded unit attached for people who are hearing impaired.

Daltson ward – 18 bed male low secure ward for people with an ABI.

Leo ward – 11 bed locked ward for men with autistic spectrum disorder (ASD). Patients on the unit have a primary diagnosis of an ASD often accompanied by co-morbid conditions and/or a history of challenging behaviour.

Hopkins ward – 4 bed locked ward for females with autistic spectrum disorder (ASD). Patients on the unit have a primary diagnosis of an ASD often accompanied by co-morbid conditions and/or a history of challenging behaviour.

There is a registered manager, accountable officer and nominated individual for this location.

The service is registered to provide the following regulated activity:

Assessment or medical treatment for persons detained under the Mental Health Act1983.

NHS England and the north west secure commissioners fund the care of patients in the medium and low secure wards. Patients admitted to the non-secure services are funded by their locality clinical commissioning group. St Mary's Hospital accepts referrals from across the United Kingdom and from Ireland.

The provider has had one previous inspection in November 2013. They were found to be meeting the required standards at the time of inspection. This is the first comprehensive inspection completed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection team

Team leader: Allison Mayoh, Inspector, Care Quality Commission

The team that inspected the location included two CQC inspectors, a Mental Health Act reviewer, an assistant inspector, a nurse specialist in learning disabilities and acquired brain injury, a clinical psychologist whom specialises in learning disability and an expert by experience.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 12 patients who were using the service and two carers;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with 20 other staff members; including doctors, nurses, occupational therapist, psychologist;
- spoke with an independent advocate;
- attended and observed a multi-disciplinary meeting;
- Looked at 20 care and treatment records of patients:
- carried out a specific check of the medication management on five 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 spoke with 12 patients and two carers. Most were positive about the care, and treatment they received from the hospital. All patients agreed that they felt safe on the wards.

Patients told us that the advocacy service that was provided was good and that they were visible on the wards.

Patients told us that they were orientated to the wards and the hospital on admission.

Patients complained about the food that was provided by the hospital in relation to the quality and the portion sizes of the food. The patients that were in independent flats catered for themselves. They told us that they were happier they were able to budget and choose their own menus and food.

Some patients told us felt that agency staff had "bad attitudes".

Patients told us about the patient forum and that they felt that this was a positive meeting, that requests were considered and actioned where they could be.

Some patients told us that there were a variety of activities and groups that they were able to attend; others felt that the activities available were not what they enjoyed.

Areas for improvement

Action the provider MUST take to improve

- The provider must consider how it will support the communication needs of the deaf population on Adams ward.
- The provider must consider the format in which information for patients is provided

Action the provider SHOULD take to improve

- The provider should ensure that staff are meeting their target for mandatory training.

Summary of findings

- The provider should consider what additional training in acquired brain injury and autistic spectrum conditions could be made available to staff to help them perform their role.
- The provider should ensure that staff are bare below the elbow including false nails in clinical practice.
- The provider should consider how to present the patient with their care plans and how this will be done in a format that is individual to the patients communication needs.
- The provider should consider how it would improve the patients' experience of food they receive.
- The provider should ensure that disposable sharps boxes are correctly labelled when opened.
- The provider should ensure that there is clear documentation for how the decision is made that a patient lacks capacity.

St George Care UK Limited

St Mary's Hospital

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Adams Ward	St Mary's Hospital
Cavendish Ward	St Mary's Hospital
Dalston Ward	St Mary's Hospital
Leo and Hopkins Ward	St Mary'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.

- Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medication charts where required.
- Mental Health Act paperwork showed that all patients were lawfully detained.
- Patients were informed of their rights in accordance with section 132 on admission. There was a system in place to remind patients of their rights every three months.
- Effective systems and processes were in place for the administration of the Mental Health Act (MHA) and ensuring that detention documents were scrutinised and correctable errors were corrected.
- Together Advocacy provided an independent mental health advocacy (IMHA) service. This included a specific IMHA for patients who are deaf.
- We conducted a Mental Health act review on Adams ward during our visit. Concerns that were identified during this visit have been included in the report.

Previous Mental Health Act visits found that there were issues:

- High number of staff leaving, this had now been fully addressed with the provider no longer switching to short day shift patterns.
- Regular updates of care plans and risk assessments were not evidenced. This had been fully addressed

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we spoke with demonstrated awareness of the Mental Capacity Act (MCA) and there was a process to follow should they have to make a decision about a person's capacity to consent.
- We found that although capacity assessment took place, the decision making process was not recorded.
- There were policies in place for both the Mental Capacity Act and the Deprivation of liberty safeguards.
- Staff had received training in the MCA.
- The provider demonstrated that it understood the principles the Deprivation of liberty safeguards (DoLs) and followed the guidance in place for those who were subject to DoLs.
- There was access to an independent mental capacity advocate for those who lacked capacity.

Good

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

Safe and clean environment

The design of the wards meant there were many blind spots, which hindered observation of patients. This could result in unwitnessed incidents occurring. However, we saw a sufficient staff on the wards to keep patients safe in these areas. Patients with an increased level of risk were nursed on increased observation levels that reduced the risk of incidents occurring.

Each ward had a completed ligature risk assessment, this identifies places to which patients intent on self-harm might tie something to strangle themselves. High risk areas had been identified across the wards and action plans had been put in place to remove these risks through the maintenance schedule. Where the risks remained, these were managed locally by increased staffing levels, risk assessment of individual patients and supportive observations. However, we did find that although ligature risk assessment and action plans were in place where those risks that were managed locally there was no written procedure for how this was done. Staff did tell us that verbal handovers occurred of each individual patients' risks to those staff who were unfamiliar with the wards which reduced the risk of patients' harming themselves through the use of ligatures. Ligature cutters were also available for staff to access on each ward.

All wards were single sex. Hopkins ward was the only female ward within the hospital this was a four bedded ward attached to Leo ward. This complied with the Department of Health guidance for same sex accommodation.

The clinic rooms on all the wards had medical equipment and emergency drugs. These were checked on a daily basis. Resuscitation equipment was available on Adams ward and Daltson Ward. Cavendish ward, Leo ward, and Hopkins ward had signs visible around the ward to alert staff to where their allocated resuscitation equipment was.

The hospital had a service level agreement with a nearby pharmacy. When equipment was broken or faulty, the pharmacy would be told and this would be replaced. We found two sharps disposable boxes on the wards that were open and in use but had not been signed, dated or the ward name printed on the label. This meant that if a sharps injury were sustained during the disposal of the sharps box, staff would be unable to identify where the needle came from and what the potential risks were to the staff member.

The wards were mostly clean and tidy with a good standard of furnishings. However, on Leo ward we saw that an unused patient bedroom had not been cleaned since the previous patient had been discharged and was waiting a through clean. On Daltson ward, some areas that were used for storage were untidy and disorganised. We saw the infection prevention link nurse for each ward completed an environmental infection prevention control audit every three months. Any areas of concern were highlighted on an action plan and tasks to be completed were allocated out to staff for action such as the housekeeper, maintenance or the nursing team.

We found a number of staff on the ward who were not bare below the elbow, who wore false nails. This could be harmful to patients as these harbour bacteria and germs under the nails even following hand washing. This could also be harmful to patients during any physical intervention.

We saw that all staff on duty carried keys and alarms. When staff entered the building they handed in a token and would receive their keys and an alarm. Staff had lockers outside of the wards in staff room areas that they were able to leave any personal belongings. This meant that staff were able to raise an alarm should they feel that they were at risk of harm.

Adams ward had a seclusion room that was accessed by going down two flights of stairs. The seclusion room included an en suite toilet and showering facility. Heating and lighting were controlled externally and a clock was located in a position that would be visible to the secluded patient in accordance with the Mental Health Act Code of Practice. However, there was no intercom and staff told us that the hatch in the door could be opened to aid communication. We saw that the seclusion room had a window but the blinds were permanently closed to protect the secluded patient's dignity as patients using the cafe could overlook it.

Good

Are services safe?

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There were plans to relocate the seclusion room to a flat that was currently being used by Leo and Hopkins ward on the second floor.

The service manager informed us that seclusion was very rarely used. None of the current patients on the ward had been secluded, and the information, we received from the provider showed there were no episodes of seclusion from July 2015- October 2015. The patient safety awareness team and the service manager had developed a risk assessment and plan for accessing the seclusion room should it be required.

Safe staffing

Each ward had its establishment estimated on the ratio of numbers of staff to patients. Adams ward worked with nine staff am and pm, seven staff at night, and one twilight shift (7pm until midnight). Daltson ward worked on seven staff am and pm, six staff at night with one twilight shift. Cavendish ward worked on five staff am and pm and four staff at night. Leo and Hopkins ward were staffed as one ward and had 16 staff am and pm, 13 staff at night with two twilight shifts. On the day of inspection, we found that the complement of staff matched or exceeded this planned daily amount. Staffing exceeded the planned number where supportive observations were in place. Where supportive observations were required, each ward would not increase their staffing for the first observation but would increase it by one staff member for any additional observations.

In October 2015 the reported establishments levels for qualified nurses whole time equivalent (WTE) were:

- Adams ward - 4.5
- Daltson ward – 6
- Cavendish ward – 3.6
- Leo and Hopkins ward – 6

For the same period the reported establishment levels for rehabilitation co therapists (RCT) unqualified nurses (WTE) were:

- Adams ward – 32.7
- Daltson Ward – 29.4
- Cavendish ward – 18.2
- Leo and Hopkins ward – 37.7

The number of WTE vacancies for qualified nurses were:

- Adams ward - 1.5
- Daltson ward – 1
- Cavendish ward – 1.3
- Leo and Hopkins ward – 1

The number of WTE vacancies for RCT unqualified nurses were:

- Adams ward – over established by 17%
- Daltson ward – over established by 5%
- Cavendish ward – over established by 21%
- Leo and Hopkins ward – over established by 1%

However, during the inspection we were told that the wards did not have any qualified nurse vacancies as these had now been filled. New staff were either on about to start induction.

Number of shifts filled by bank and agency from July 2015 – October 2015:

- Adams ward qualified – 20
- Adams ward RCT unqualified - 117
- Daltson ward qualified – 40
- Daltson ward RCT unqualified – 134.5
- Cavendish ward qualified – 16
- Cavendish ward RCT unqualified – 61
- Leo and Hopkins ward qualified – 27
- Leo and Hopkins ward RCT unqualified - 211

The service managers for each ward told us that due to the patient group some patients required long-term supportive observations that meant that they would require one staff member or more with them at all times. This increased the daily establishment for the wards and increased the amount of bank and agency staff used. The provider had agreed that for those patients who had a clinical need for long-term one to one supportive observations, the wards could recruit to those posts over their established numbers. This would reduce the amount of bank and agency staff used and create more consistency in the staffing and therefore the care received by the patients. All wards with the exception of Leo and Hopkins were established up to this level. Leo and Hopkins wards were in the process of recruiting an additional 20 RCT unqualified staff above their establishment.

The service managers we spoke with all agreed they would be able to increase the staffing should the clinical need arise. In the first instance this would be offered to the substantive staff, then bank and following this they would use agency as a last resort.

Good

Are services safe?

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

Sickness levels were low in all areas, below 2%, with the exception of Cavendish ward where this increased to 26% for qualified nursing staff. This was reported to be high due to the overall establishment for the nurses on this ward being low at 3.6 WTE that meant that one person's sickness would increase the percentage of sickness for that service.

All the staff we spoke with said that leave, one to one time and activities were rarely cancelled. Leave and activities were prioritised and if the wards were short staffed the wards would support each other to enable activity and leave to be facilitated. The registered manager (RM) and a number of qualified staff told us that if leave was cancelled then a form had to be completed which was sent to the RM and forwarded to NHS England. The RM said that she encouraged that all planned leave that had to be deferred to also be reported in this way. In the three months prior to the inspection only one identify period of leave had been cancelled.

There were sufficient medical staff on site during the day to respond to an emergency. Out of hours there was an on call rota for responsible clinicians and staff grade doctors, who provided advice over the phone for non-urgent queries or attended within 30 minutes if necessary. For physical health concerns out of hours, staff contacted the out of hours GP or in emergencies contacted an ambulance or took the patient to accident and emergency (A&E).

The levels of mandatory training as of December 2015 for Cavendish ward were above 75%. However, Leo, Hopkins and Adams ward fell below 75% in infection control, information governance, incident reporting, and health and safety. Daltson and Adams wards were both below 75% for autistic spectrum conditions and acquired brain injury training. All wards were above 90% for basic life support training, and reported that 20 qualified nurses had immediate life support training. The registered manager provided an action plan that showed plans to increase compliance with mandatory training. Bank staff employed by St Georges Care UK LTD also received the same mandatory training as substantive staff before starting work in clinical areas.

Assessing and managing risk to patients and staff

We reviewed 19 risk assessments. These reflected the patients' risks and management plans showed how identified risks were to be managed. We found that in other areas of the case files such as getting to know me plans and positive behaviour support plans there were detailed profiles that explained warning signs, triggers and descriptions of behaviours that could be displayed and how to manage these. We observed a multi-disciplinary team meeting in which all patients' risks were discussed and pre review sheets were in place that prompted discussions of a person's risk. For those patients within the medium and low secure wards an historical clinical risk management-20 (HCR-20) tool was completed. All risk assessments had been reviewed and updated regularly.

There were no incidents of seclusion or rapid tranquilisation over the period of April 2015 to October 2015. However, there were 410 restraints over that same period. Leo and Hopkins ward had the highest number of restraints. Leo ward had 203 restraints that involved 10 patients and Hopkins ward had 98 restraints that involved three patients. There was one reported prone restraint on Adams ward.

There was a 'no force first' ethos amongst the staff, this is where staff are trained and there is a culture of using other skills and resources to manage patients who are distressed or in crisis. The 'no force first' ethos, uses only as a last resort to prevent harm to a patient or others, restraint or force. Staffs initial training in managing violence and aggression (personal safety awareness or PSA) was for five days and included three-day de-escalation and two days physical intervention. Staff had annual refresher training. Staff were clear that they were taught not to place patients in prone restraint (face down) and to manoeuvre patients that initially fall in to prone restraint in to supine (face up).

On reviewing the incident data on the wards there was clear evidence that there was a difference between a full restraint, where a patient can be immobilised to reduce risks to themselves or others, and a passive restraint. This was where staff used their PSA techniques to guide patients away from a situation or incident. Both were recorded on their electronic incident recording system as a restraint.

A new service manager had been in post since March 2015 on Leo and Hopkins ward who was a trained and registered positive behaviour support therapist. The registered manager had identified that since the introduction of the service manager there had been a reduction in incidents on Leo and Hopkins ward. However, there had been no formal analysis of this at the time of inspection, but the information received from the provider for the three-month

Good

Are services safe?

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

period October 2015 to December 2015 showed that there had been a reduction in the number of restraints to 43 passive restraints and 46 full restraints for both Leo and Hopkins ward.

St George Care UK Limited ran a blanket restrictions group following the introduction of the new Mental Health Act code of practice. This group was formed to look at all the hospitals across the group and to review practices that were in place that could be considered a blanket restriction and whether alternative ways to reduce these restrictions could be considered and implemented. St Mary's Hospital showed that they had thought about their restrictions on patients during the inspection and had identified issues such as hot drinks and blanket personal searches as areas of restriction. All the wards had a hot and cold drinks dispenser that patients had access to 24 hours a day and searches of patients were now conducted on individuals according to risk.

On reviewing the minutes of the blanket restrictions group, we found that other restrictions were being discussed for the medium and low secure wards in particular around access to graphic films and games, mobile phones and internet access.

At the time of inspection, there were no informal patients.

Medication was supplied to the hospital through a service level agreement with a community pharmacy. The GP for the hospital prescribed any newly prescribed physical health medication and the responsible clinician (RC) prescribed all other medications. The GP had an electronic prescription system that sent the information straight to the pharmacy for ordering. The RC wrote a prescription that was faxed to the pharmacy. The pharmacy dispensed the medication for individual patients. Medication was ordered on a repeat basis unless there were any changes to their medication. A pharmacist attended the wards on a monthly basis to review the wards' stock levels, review the prescription charts and audit the medication charts. The registered manager authorised any additional emergency medicine deliveries for those who may be prescribed additional medicines such as antibiotics.

We looked at 50 prescription charts and found them to be in line with prescribing guidelines. There were no missed doses evident. All patients had their date of birth and allergy status clearly displayed. Photos of patients were present either on the card or within the file. All files held the consent to treatment forms where required. This showed that medication was being administered in a safe way.

Staff were aware of the safeguarding procedures, different types of abuse and what they should do if a concern arose. St Mary's Hospital reported a high number of safeguarding concerns to the Care Quality Commission through statutory notifications. These were mostly low-level patient on patient clinical incidents but were still treated as safeguarding by the hospital. Good local links were in place with the safeguarding team in Warrington local authority (LA). An informal agreement was in place, as some incidents that were reported to the local authority did not meet their threshold for safeguarding. The registered manager (RM) completed a monthly form of all incidents that the hospital categorised as safeguarding with any actions and outcomes. This was emailed to Warrington safeguarding team for their records. Any incidents that did meet the threshold for the safeguarding team a form was completed by the nurse in charge of the ward which was embedded in their daily handover forms and was sent to the RM and then to the LA. A follow up telephone call and discussion took place regarding the incident and any actions and outcomes. However, we found that one incident that was a safeguarding concern was not reported. The provider had put steps in place locally to safeguard others in this instance.

Track record on safety

There were six serious incidents from May 2015 to October 2015. These all related to allegations of abuse.

- Leo ward – 4
- Daltson ward -1
- Hopkins ward – 1

Five of these incidents related to the care and treatment patients had received from staff. They were all investigated internally. Two were found to be substantiated and appropriate actions were taken. Three other incidents were found to be unsubstantiated by police investigation and review of CCTV footage. One other incident was due to a historical allegation made against another patient. The care team put risk management strategies in place to manage the patients' contact with each other, and the police and locality care team conducted a formal investigation.

Good

Are services safe?

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

All the incidents were reported to the Care Quality Commission and the local safeguarding teams.

The most recent serious incident was an unexpected death of a patient that occurred in November 2015. Staff were all aware of the incident and an investigation was ongoing at the time of the inspection.

Reporting incidents and learning from when things go wrong

The hospital used an electronic incident reporting system. Staff were aware of the different categories of incidents that they should report and how to report these. When incidents occurred patient's families had been contacted. However, some staff were not aware of what the duty of candour was but were able to tell us that they would apologise when things went wrong.

We found that staff had opportunities for debrief following incidents, and that following any serious incident the report and lessons learned from the investigation were shared with the team. Following a recent incident on Adams ward, staff there told us that there had been significant support available for the patients and the staff of debriefing, counselling and spiritual support.

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

Assessment of needs and planning of care

We looked at the care and treatment records for 20 patients. We found that patient care plans were up to date, person centred and described the needed of the patients. On Leo and Hopkins wards, positive behavioural support plans and 'all about me' booklets were in place for patients and they were of a good standard. All patients had health action plans, communication plans and my support and recovery plans.

Patients that were accepted for admission were transferred with care plans from other services. Initial care plans and risk assessments were completed based on the previous assessment and the care plans already in place. A 12-week multi disciplinary assessment was then completed.

In the 20 care records we reviewed, we found that all patients had health action plans in place where there was a clinical need. Health action plans were detailed and covered all areas of physical health care such as epilepsy, diabetes, and heart conditions.

A general practitioner (GP) attended the wards on a sessional basis and saw patients regarding their physical health needs. All patients were registered with the GP. On admission, the staff grade doctor completed a physical health examination within 24 hours.

The clinical records were in a paper-based format, and there was a standard layout for how the records should be kept. These were stored in a lockable cabinet in the ward staff office. On reviewing these files, we saw that these were very large and previous records had to be archived to ensure that the records in the patients' files were current. However, staff found this difficult when review they had to review historical information. Staff who we spoke with said that there was a lot of duplication that occurred within the care records and this could be time consuming and took time away from direct patient contact.

Best practice in treatment and care

We reviewed 50 prescription cards and found that medications were prescribed within the British National Formulary (BNF) limits. The BNF is a pharmaceutical reference book of information and advice on prescribing and pharmacology, along with details of medicines available on the NHS including indications, contraindications, side effects, and doses.

Rapid tranquilisation was only used in exceptional circumstances. There was recognition amongst staff that combined antipsychotic and benzodiazepine medication was not helpful for their patient group, and that low doses of benzodiazepine or an antipsychotic medication would have a better effect.

Psychological therapies were available across on all the wards, from tailored individual one to one work to dialectical behavioural therapy (DBT), and addiction awareness groups. This was in line with the current National Institute for Health and Care Excellence guidance.

Standardised assessments and rating scales were used to measure outcomes and plan care. These included the Health of the Nation Outcome Scales for learning disability and secure services (HoNOS), adaptive behaviour assessment system 2 (ABAS2) and Wechsler Adult Intelligence Scale fourth edition (WAIS4).

The clinical team participated in clinical audits such as infection control, health and safety, fire, medication and prescription charts. These were completed on a six monthly or quarterly basis.

Skilled staff to deliver care

There was a full range of disciplines working across the hospital. This included occupational therapists, psychologists, a social worker, consultants and staff grade doctors, nurses and rehabilitation co therapists. There were professionals that also provided input from outside agencies such as GPs and pharmacists. Once a week a team of professionals attended the hospital from another hospital within the group, this was specifically for the deaf patients on Adams ward.

A week long induction programme covered all the mandatory training, including basic acquired brain injury (ABI) and autistic spectrum disorder (ASD) training. Following this staff spent a week shadowing staff on the ward, followed by a five-day personal safety awareness course. Unqualified staff that started after April 2015 completed the care certificate training.

There was no identified formal additional training for ABI or ASD other than the basic training received on induction.

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 were a number of staff who were trained in level one and two British sign language but there were only four staff trained in levels four, five and above. This meant that the patients within the deaf service could not always communicate with staff in their preferred method.

Most staff received regular line management and clinical supervision. However, on Leo and Hopkins wards this was less frequent and not in line with the hospital's policy of monthly supervision. The registered manager (RM) and service manager (SM) acknowledged the difficulties with the levels of acuity on this ward in ensuring that supervision occurred and had been working to try to put suitable processes in place. The RM and SMs all operated an 'open door' system where staff could approach them at any time.

We reviewed the team meetings for all the wards and found that staff had access to team meetings on each ward, which covered issues such as complaints and compliments, activity, HR issues and ward issues. A staff forum was held monthly by the RM, where staff could bring wider issues that are more organisational to the meeting. For example, recently there had been discussion around the change of shift pattern that staff did not want to happen and their concerns were raised during this meeting.

All medical staff had received an appraisal and had been revalidated. Fifty four percent of non-medical staff had received an appraisal. The RM explained that the appraisal for 2015 had been a 360 degree appraisal that was reliant on a self-assessment and gaining feedback from other colleagues. It had been recognised that this type of appraisal had not worked as well as they had expected and were looking at developing an alternative form of appraisal for the coming year.

Multi-disciplinary and inter-agency team work

Weekly multi disciplinary team (MDT) meetings occurred on each ward, and patients were seen on a two weekly basis or weekly if the clinical need arose. The MDT consisted of the responsible clinician, staff grade doctor, clinical psychologist and nursing staff. The occupational therapist (OT) attended on a needs led basis.

The hospital had a standard template that was to be completed prior to the MDT meeting by the named nurse. This covered all areas of 'My Shared pathway', and risk assessment it held the patients views of their care and treatment and their wishes for the outcome of the MDT. We saw that the front sheet of the template held demographic details but also the preferred method of communication, risk history and any index offences, both mental and physical health diagnosis, consent to treatment status, and compensatory aids.

We observed an MDT meeting for Cavendish ward. We found that there were full and open discussions regarding patients presenting needs, risks, and patient's wishes were taken into consideration. Risks were discussed and balanced as to whether a patient's requests were agreed. Discharge status was also discussed and possible future placements However, the care co-ordinators for the patients did not attend the MDT meeting but attended 3-6 monthly care programme approach (CPA) meetings. Discussion with patient's care co-ordinators around placements and discharge arrangements took place outside these meetings.

On each ward there were handover booklets for staff to access that the nurse in charge completed. Due to the shift pattern of long days, handovers occurred in the morning and in the evening. These covered areas such as observation level, diagnosis, risk and other relevant information about the patient.

There were effective working relationships outside of the organisation. This was particularly evident with Together Advocacy, the general practitioner, and the safeguarding leads within the local authority.

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

The compliance in Mental Health Act training varied across the hospital, from the lowest being 88% on Adams ward to 100% on Daltson ward. The qualified staff we spoke with understood the Mental Health Act and the principles of the Code of Practice that were relevant to their service. The rehabilitation co-therapists however were aware of the Mental Health Act but did not have detailed knowledge. They said they would seek advice from the qualified nurse for any questions around this.

We reviewed all the medication charts and found that treatment was given under an appropriate legal authority. Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medication charts where required.

Are services effective?

Good

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Patients were informed of their rights in accordance with section 132 on admission. There was a system in place to remind patients of their rights every three months. We were informed that an easy read version of section 132 information was available. However, we were unable to find evidence that this information was provided in a specific deaf-friendly format.

We found that effective systems and processes were in place for the administration of the Mental Health Act (MHA) and ensuring that detention documents were scrutinised and correctable errors were corrected within the specified period in accordance with the MHA and Code of Practice (CoP).

Audits were completed quarterly and six monthly by the MHA administrator and service managers reviewed compliance with section 132 rights, section 17 leave, and consent to treatment.

Together Advocacy provided an independent mental health advocacy (IMHA) service. This included a specific IMHA for the deaf patients in addition to the IMHA allocated to the wards. The IMHA informed us that they had a regular presence on the wards that ensured that they were able to approach new patients on admission. There was information available on the ward that included facts and myths about advocacy.

Good practice in applying the Mental Capacity Act

The compliance with the Mental Capacity Act (MCA) training varied across the hospital, from the lowest being 88% on Adams ward to 100% on Daltson ward.

There was one Deprivation of Liberty Safeguards (DoLS) in place at the time of inspection. The hospital had made a further request to the local authority to renew the DoLS application in November four weeks prior to the DoLS authorisation ending on the 10 December 2015, the application was authorised on the 7 January 2015. However, we saw that the patient had all the appropriate best interest meetings and medical assessments in place to support the renewal.

The staff we spoke with demonstrated awareness of the MCA and there was a process to follow should they have to make a decision about a person's capacity to consent. However, we were unable to find clear recording of the process or decision-making that had led to capacity decisions being made.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed staff treating patients with kindness, dignity and respect, Staff that we spoke with spoke positively about patients and understood their individual needs. We observed the care of two patients that had limited and or no verbal communication over a period of 30 minutes to see how staff and patients interacted. We found that staff engaged in mostly positive interactions, where staff encouraged the patient to join in activity and supported their needs by responding to their non-verbal cues. However, we also saw that on a couple of occasions staff did not engage in the activity with the patient but held conversations between themselves.

We spoke with 12 patients. The majority of them said that the staff were kind and caring, and made comments such as, 'staff are great to us all in here', and 'every time I get upset staff hold me to comfort me'. One patient however, commented that agency staff had "bad attitudes" toward patients. Three patients told us that staff could use humour to defuse difficult situations, which could be positive however; they did think this could have the effect of being misunderstood.

The involvement of people in the care that they receive

Patients that were able to remember told us that they were orientated to the ward on admission by the nursing team.

Most of the patients said that they did not know what a care plan was or if they had one. The few patients that did tell us that they had a care plan explained that they did not understand them as they were written in a way that was very wordy, complicated or for the deaf patients this was not written in the correct syntax. Patients did know that they had a programme of activity or knew what was happening for them on a daily basis. Due to the nature of the disorders experienced by this patient group, it was recognised that patients within the hospital might forget that they had a care plan. However, we did not find any evidence to say that care plans were re visited at regular intervals with patients.

We observed that during a multi disciplinary team meeting, patient's views around their care and treatment were taken into consideration and where it was possible it was agreed on such as patients wanting to attend the cinema or have more leave home to family.

There was good access to advocacy services within the hospital including provision of a deaf specialist advocate. Community meetings took place weekly that gave patients the opportunity to have their say about the ward environment, activities, food and staffing. A patient's forum had also been developed so that patient representatives can take their feedback to the senior managers. Patients told us that they had recently asked managers for a TV and sports channel to be added to the café and this had been listened to and actioned.

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

Access and discharge

The hospital offered medium, low and locked rehabilitation services and accepted referrals from a national catchment area. The hospital did not accept emergency admissions. All admissions were assessed and pre planned. However if beds were available admission could happen quickly.

Referrals for patients requiring secure care were received from NHS England, and for those who were requiring locked rehabilitation, referrals were received from locality teams around the country. All referrals were discussed at a weekly referrals meeting. This was followed by an assessment from a responsible clinician and nurse from an identified ward. All assessments that were completed were discussed in the weekly referrals meeting to look at the person's suitability for admission.

Patients were not moved between the wards as routine but could be stepped down to low secure or to the locked rehabilitation services. However, this needed discussion with the patient's locality team usually through the CPA processes and also funding needed to be agreed through NHS England or locality Clinical Commissioning Groups (CCG), this at times delayed those transfers.

Delays that occurred were due to difficulties in finding placements for patients who were ready to be discharged from the hospital. This was due to the complexity of needs of the patient groups, particularly around finding placements that were able to manage long term challenging behaviour and complex physical health care.

Between April 2015 and September 2015, there were five delayed discharges; there was one delayed discharge on each ward. This was due to awaiting community placements, parents challenge on placement found and funding issues.

The average bed occupancy over the 6 month period April 2015 to September 2015 was:

- Leo ward – 78%
- Hopkins ward - 68%
- Cavendish ward– 98%
- Adams ward – 86%
- Daltson ward – 99%

At the time of inspection, there were waiting lists for three of the wards, Cavendish had two patients waiting, one of which was due to be admitted the week of the inspection, two on Adams ward and one on Leo ward. Due to the specialist nature of the services provided patients can wait for beds to become available. The longest waiting patient was for 6 months from August 2015 to January 2016 and the hospital maintained contact with the locality service and CCG's throughout.

The facilities promote recovery, comfort, dignity and confidentiality

Each ward differed in its design; all wards were male wards with the exception of Hopkins ward. There were clinic rooms in each ward area that were spacious and contained enough equipment to carry out routine physical examinations. However, there were no examination couches in these areas and any examination that required patients to lie down was conducted in the patients' bedrooms.

Each ward had quiet areas or areas where patients could spend some quiet time. There were off the ward facilities such as a gym, café, and therapy centre. Each ward had an off the ward visiting area for patients to meet with their visitors in private, which was accessible from ward area.

There was a structured programme of activities specifically around groups that were planned by the therapy team. There were individual activities also planned for each patient that included community leave, college courses, and structured activity. However, patients told us on Leo ward that activities only happened Monday to Friday. Patients from the other wards had mixed views about the activities that happened. Some said that there was plenty happening, and they were 'pretty good', others felt that it did not meet their needs such as bingo and adult colouring.

The hospital did offer a permitted earnings scheme (PES) to patients over a 12-week period. Patients who were interested in an advertised job role completed an application form and then the therapy team, alongside the Multi-Disciplinary Team, considered whether they should take on the role. The jobs available included assisting in the tuck shop and cleaning the outside quad area. The roles varied in the time and the number of days they would be completed and patients were paid money for completing their tasks.

There was a payphone in a private space on each ward. The payphones were operated by a token on all wards with the

Are services responsive to people's needs?

Requires improvement

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

exception of Daltson ward that was money operated. Tokens for the pay phone were obtained from the ward staff. The deaf people on Adams ward had access to their mobile phones so they could use text messaging and emails to communicate with others.

Patients had access to a hot and cold drinks machine 24 hours a day on all the wards, and snacks were available on request. Patients personalised their bed spaces, and where risk assessed had televisions, DVD players and other electrical equipment.

Meeting the needs of all people who use the service

All wards had door spaces that would allow access for those requiring disabled access, and en suites had wet rooms. Daltson and Adams ward were based on the first floor of the building and lifts were available for those unable to use the stairs. All patients who resided on the first floor had a personal emergency egress plan (PEEPs) tailored to meet their individual needs.

The wards had a lot of information displayed relating to complaints, advocacy, the Mental Health Act, sign posting to other services, and groups and activities available on the ward. However, most of the information we reviewed was found to be lengthy, wordy and difficult to understand, which did not cater for the needs of the hospital's specific patient groups.

The unit had access to interpreters and British sign language (BSL). This was requested usually as and when it was required but for those patients that were deaf, these were used at each multi- disciplinary meeting and where there were formal assessments that were required to be carried out outside of the MDT. One staff member that worked within this service was deaf, and four others had been trained to BSL level four, five or above which would be to a standard in which would allow fluent conversation. BSL interpreters were not available for deaf patients on a daily basis and there were clear communication barriers that were identified by the deaf population of Adams ward. For example when trying to lip read they were not able to follow what others were saying if they had an accent, or if in a large group such as a community meeting or therapy group they were not able to follow the flow of the group conversation. This meant that the deaf population were not able to communicate in their preferred method and the provider did not meet the needs of this patient group at all times.

The food menu was based on a four-week rota. Patients had to choose at the start of each week what meals they would like for that week. We were told as there was in house catering and that all food was freshly cooked, this was to allow the ingredients to be bought for that week. We were told that there was an option that if patients changed their mind that catering could be contacted and the meal option changed. The patients gave negative views about the food. Some complained that 'there were no options' or the food is 'not warm when it arrives' or that it's 'not bad' or the portion sizes were too small. Those patients that resided in flats had a food budget and made their own food that they enjoyed. One patient specifically complained about the time of the teatime as this was between 4pm and 4.30pm, which they felt, was very early and made the evening stretch out. There had been three complaints from October 2015 regarding the standard of the food received by patients.

Listening to and learning from concerns and complaints

All the wards had compliments and complaints boxes in the day areas that were emptied each day. The hospital had a good complaints procedure in place, where the registered manager dealt with any complaints. The patient would be spoken with and written to within 48 hours to acknowledge their complaint. The complaint would be investigated and completed within 20 working days. There had been six complaints from October 2015 to December 2015. All six complaints had been managed in line with their own policy with relevant actions taken to resolve the complaint for the patient. However, there were three complaints within this period around the standard of food received by patients.

The registered manager acknowledged that low level locally resolved complaints were not recorded. A verbal complaints log had been recently set up to enable them to capture this information to review themes.

Ten patients we spoke with all felt that they knew how to complaint and would feel confident in complaining. Two of the patients we spoke with said that they had made a complaint and that these were investigated with a good outcome. There were only two patients that said that they did not have confidence in the complaints system as 'nothing ever gets sorted' or staff say 'I'll pass it on' and this does not happen.

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

Vision and values

St Mary's hospital had corporate values which were:

- Delivering Excellence - Patient Centred, Efficient Clinical and Non-Clinical Services
- Working Together - Learning From Each Other, Collaboration and Teamwork
- Respecting People - Valuing Staff, Patients, and Encouraging Diversity
- Being Ethical In All We Do - Integrity, Transparency and Accountability
- Leadership - Leads by Example, Encourages Innovation and Takes Accountability

We saw that these were posted in the main reception areas of the hospital, but were not prominent on the wards. Staff we spoke with said that they understood the values and spoke of team working, patient centred care however, this showed that the values were not fully embedded at ward level.

The vision and values of the organisation were not incorporated in to staff performance appraisals, though we were informed that the staff performance appraisal did look at the person's own values.

Staff told us that the registered manager and other senior managers were approachable, and they had an 'open door'. All the staff said that the registered manager was highly visible on the wards.

Good governance

There was a governance structure in place, and regular meetings occurred that ensured quality and safety at the hospital was monitored and reported from ward level to the board level. This included health and safety, patient and staff forums, local incident monitoring groups, and physical intervention groups. The registered manager had a good level of oversight of the hospital's strengths and areas for improvement.

The hospital had a risk register in place that was up to date and, the risks identified were all managed effectively. The service managers had a quality action plan for each of their areas which included all outstanding action from audits and inspections so this showed that they had clear oversight of all there areas of improvement. This was monitored in one to one supervision.

The hospital was working towards ensuring consistency of staffing by over recruiting so that they were able to staff longer-term supportive observations of patients. However, there were a number of these posts still vacant particularly on Leo and Hopkins ward.

The service managers had access to their key performance indicators (KPI). These were specifically around sickness monitoring, bank and agency usage, and incidents. They showed us how these were monitored through supervision. However, they were not able to describe what their commissioning for quality and innovations target were.

The service mangers told us that they felt that they had sufficient authority to do their job; they also had enough administrative support to ensure that they were able to complete their work requirements.

Leadership, morale and staff engagement

The staff we spoke with all said that they felt supported by the service managers and the registered manager. They had said that previously morale had been low as staffing had been poor as staff left when the organisation tried to change the shift pattern to short shifts. However, issues around the shift pattern had been raised within the staff forum and it had been agreed that the shift pattern would remain the same. Therefore, staff felt listened to, staff that had left returned to the hospital and morale had improved.

Staff felt that they were able to approach their managers with any concerns and were aware that that they could escalate concerns should they not be happy with the outcome.

Staff felt that they received the right amount of mandatory training and that there were other courses, which were available for their own personal development. However, staff identified specific training in acquired brain injury and autistic spectrum conditions to be lacking and that there was a lot of learning 'on the job'.

Commitment to quality improvement and innovation

Adams ward was participating in an initiative called safewards; this has a number of modules in which the patients and the staff worked together with the aim of making the ward a safer and calmer place. The modules included reviewing mutual expectations, getting to know each other, and mutual help meetings.

Are services well-led?

Good

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The hospital group held a blanket restrictions group, which was seen to be a positive initiative that was brought in following the new Mental Health Act Code of Practice in April 2015. This looked to improve the experience of patients on the wards by reducing restrictions placed on them and moving towards a more individualised risk based decision making around restriction placed on patients.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must enable and support relevant persons to make, or participate in decision making relating to their care to the maximum extent possible and provide information that they would reasonably need to do this. Information displayed on the wards was found to be lengthy, wordy and difficult to understand. This did not meet the needs of the patient group in the hospital. This was a breach of regulation 9 (3)(d)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced persons. British sign language interpreters were not used on a day-to-day basis and the hospital did not have enough sufficiently skilled staff in BSL to ensure that the deaf population were able to communicate in their preferred way. This was a breach of regulation 18 (1)