St. Matthews Limited

Broomhill

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services caring?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This was a follow up inspection in response to enforcement action we had taken. We looked at specific key lines of enquiry in safe, caring and well led. We looked at sufficient evidence in these areas to rerate. The rating in these domains has improved from inadequate to requires improvement. Therefore, the hospital has now moved out of special measures.

Our rating of this service improved. We rated it as requires improvement because:

- Ligature risk assessments in two wards were not accessible to staff. Some ligature risks did not have full mitigation documented to manage the risk. The installation of closed circuit television had not been included as mitigation on any risk assessments.
- The service did not evidence that some medical equipment had been serviced and service stickers were not in place on some equipment to show it had been tested.
- On the rehabilitation service, emergency equipment had not been checked. The provider had not ensured that spare oxygen cylinders were available.
- Three patient beds on a rehabilitation ward, did not have duvet covers on their beds.
- In both services, there was no evidence that patients and their families had been involved in incident investigations.
- Not all staff had been respectful and caring towards patients.
- Staff on the rehabilitation ward had not always responded appropriately to patients' gender issues.
- In both services, patients had not been fully involved in the development of their care plans and care plans were not written from the patients' perspective.
- Not all staff across the hospital knew and understood the provider's vision and values.
- The provider had introduced new governance processes with a number of committees and meetings. However, there was a lack of clarity about what areas were covered in each meeting which meant there was a risk of topics being repeatedly discussed or different approaches being advised.

However:

- We noted improvements in safe, caring and well led domains since our last inspection.
- All wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- The service generally had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Agency staff were block booked to ensure patients had consistent care.
- Staff stored, managed and audit medications effectively.
- Mandatory training compliance for permanent and agency staff had improved.
- Staff assessed and managed risks to patients and themselves well.
- Staff understood how to protect patients from abuse. Staff had received training on how to recognise and report abuse and they knew how to apply it. A freedom to speak guarding had been appointed and staff knew how to raise issues.
- Executive directors had the skills, knowledge and experience to perform their roles.
- New governance systems and processes were in place to improve accountability and monitor performance of the service.
- Senior managers had made significant steps to change the closed culture identified at previous inspections. Staff morale, team working and communication from ward to board and board to ward had improved. Poor performance of staff was managed effectively.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this service improved. We rated it as requires improvement because: • Curtain rails had been screwed to the wall. Managers had not identified mitigating actions for this risk. Staff on the ward did not have access to a hard copy of the most up to date version of the ligature risk assessment. • There was no documentation available to evidence that a standing frame, turn table and mattress pump had been serviced. • There was no evidence that patients and their families had been involved in incident investigations. • Not all staff had been respectful and caring when caring for patients. Two patients reported staff had not been respectful. • Patients had not been fully involved in the development of their care plans. • Not all staff knew and understood the provider's vision and values. • The provider had introduced new governance processes with a number of committees and meetings. However, there was a lack of clarity about what areas were covered in each meeting which meant there was a risk of topics being repeatedly discussed or different approaches being advised. However: • We noted improvements in safe, caring and well led domains since our last inspection. • All wards were, clean well equipped, well furnished, well maintained and fit for purpose. Lines of sight had been improved with installation of closed circuit television. • The service generally had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Agency staff were block booked to ensure patients had consistent care.

Summary of findings

- Staff stored, managed and audit medications effectively.
- Mandatory training compliance for permanent and agency staff had improved.
- Staff assessed and managed risks to patients and themselves well. Incidents had been recorded and investigated where necessary and learning from incidents was shared.
- Staff understood how to protect patients from abuse. Staff had received training on how to recognise and report abuse and they knew how to apply it. A freedom to speak guarding had been appointed and staff knew how to raise issues.
- Executive directors had the skills, knowledge and experience to perform their roles.
- New governance systems and processes were in place to improve accountability and monitor performance of the service.
- Senior managers had made significant steps to change the closed culture identified at previous inspections. Staff morale, team working and communication from ward to board and board to ward had improved. Poor performance of staff was managed effectively.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Our rating of this service improved. We rated it as requires improvement because:

- Staff did not have access to a hard copy of the most up to date version of the ligature risk assessment on Althorp ward.
- Emergency response equipment had out of date items or uncharged items, had not been checked by staff and spare oxygen cylinders were not available. Not all staff knew where oxygen cylinders were located.
- There was no evidence that patients and their families had been involved in incident investigations.
- Not all staff had been respectful and caring when caring for patients. Three patients reported that they had recently heard staff talking in a language other than English.
- Patients had not been fully involved in the development of their care plans.

Summary of findings

- Three patient beds on Althorp ward, did not have duvet covers on their beds.
- Staff had not responded appropriately to patients' gender issues.
- Not all staff knew and understood the provider's vision and values.
- The provider had introduced new governance processes with a number of committees and meetings. However, there was a lack of clarity about what areas were covered in each meeting which meant there was a risk of topics being repeatedly discussed or different approaches being advised.

However:

- We noted improvements in safe, caring and well led domains since our last inspection.
- All wards were, clean well equipped, well furnished, well maintained and fit for purpose.
- The service generally had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Agency staff were block booked to ensure patients had consistent care.
- Staff stored, managed and audit medications effectively.
- Mandatory training compliance for permanent and agency staff had improved.
- Staff assessed and managed risks to patients and themselves well. Incidents had been recorded and investigated where necessary and learning from incidents was shared.
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- Executive directors had the skills, knowledge and experience to perform their roles.
- New governance systems and processes were in place to improve accountability and monitor performance of the service.
- Senior managers had made significant steps to change the closed culture identified at

Summary of findings

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Summary of findings

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Summary of this inspection

Background to Broomhill

Broomhill is an independent mental health hospital, which provides rehabilitation and acute care, treatment, and support to individuals with mental health concerns. Broomhill is part of the St. Matthews Healthcare Limited group, which consists of four care homes and four hospital locations in Northampton and Coventry.

Broomhill is based in a rural setting with access to the local town. Broomhill provides 99 beds across seven wards:

• Holdenby ward – acute mental health services for women - 14 beds.

• Cottesbrooke ward – acute mental health services for men - 14 beds. This ward was closed at the time of our inspection.

• Althorp ward - specialist dual diagnosis rehabilitation service - 14 beds.

• Kelmarsh ward – complex mental health high dependency service for men - 14 beds.

• Lamport ward - specialist Neuro-behavioural rehabilitation for men - 14 beds.

• Spencer ward – longer term complex care service for men - 14 beds.

• Manor ward - longer term complex care service for women - 15 beds

The last comprehensive inspection of Broomhill took place in February 2020. The provider was rated inadequate overall and placed in special measures. We conducted three further inspections at Broomhill following our inspection in February 2020. These took place in July 2020, September 2020 and February 2021. Further to each inspection, a number of breaches of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 were identified.

This was evidence of a history of failing to respond adequately to serious concerns raised by the Care Quality Commission. Following an assessment of the evidence, the Care Quality Commission issued a Notice of Proposal (13 August 201), followed by a Notice of Decision (30 July 2021), to vary a condition of the provider's registration (to remove the location). The provider submitted an appeal against the proposal. In the interim, a stay of proceedings was requested and approved until Friday 19 November 2021 to allow for a further inspection to be undertaken.

The purpose of the 'stay of proceedings' was to enable the CQC to conduct a further inspection of Broomhill. This would enable the CQC to identify progress since our last inspection and determine if any of the breaches of regulation have now been addressed. As a result of this inspection, the appeal was upheld and enforcement action against the provider ceased.

The main service provided by this hospital was long stay or rehabilitation mental health wards for working age adults.

What people who use the service say

We interviewed 19 patients in total. Seventeen patients were on a rehabilitation ward, and two were on an adult acute ward.

Summary of this inspection

Three patients on the rehabilitation wards reported that they had recently overheard staff talking in a language other than English. Patients said most staff treated them well and behaved kindly. However, one patient told us that staff were 'unpleasant and unfriendly'.

We interviewed two patients on the acute ward. Both patients stated that most staff were kind. However, one patient stated that staff had made her feel 'like a second class citizen', and the other patient stated that they had heard 'staff mocking a patient behind their back' adding that 'they laughed about the patient'.

The provider was not able to identify any carers for patients on the adult acute ward, who were willing to speak with us.

We spoke with nine carers during the inspection who gave mixed views of the services. Three carers told us they had difficulty visiting the wards. Two carers said that their relative had experienced assaults when on the ward. Four carers reported positively about the environment and how clean and comfortable it was. Most carers told us staff were kind and respectful and their relative had improved whilst at Broomhill. Carers told us they saw posters about how to report issues.

How we carried out this inspection

This inspection was an unannounced, focused inspection of Broomhill, in response to enforcement action we had taken.

We looked at specific key lines of enquiry during this inspection therefore we have only reported in the following domains:

- Safe
- Caring
- Well led

Before the inspection visit, we reviewed information from the service about recent incidents that had occurred. We also reviewed feedback information we held about the service from patients, staff (including whistleblowing concerns), and carers.

This inspection took place on the 19, 20 and 21 October 2021.

Inspection Team

Two inspection managers, one inspector three specialist advisors and two experts by experience conducted this inspection.

Over the three days of inspection, our inspection team undertook the following activities:

- spoke with the chief executive officer, medical director (also the deputy chief executive officer), nurse director (nominated individual) and director of operations
- spoke with the hospital manager (registered manager)
- visited and undertook a tour of all six wards
- attended a site 'huddle' meeting
- interviewed 19 patients

Summary of this inspection

- interviewed 9 carers
- interviewed 22 ward staff, including staff nurses, senior care assistants, care assistants, psychologist, psychology assistant, activity coordinators, occupational therapist and occupational therapy assistants
- reviewed 16 care records looking at incidents, safeguarding, risk assessments, risk management plans and patient care plans
- observed patient and staff interactions on two wards.

We also reviewed information provided by the service, including:

- incident data for three months prior to the inspection
- minutes of the CQC strategy meeting and ward meetings
- the hospital's risk register and minutes of the risk register meeting
- training, supervision and appraisal data.

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Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

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

Action the service MUST take to improve:

- The service must ensure that ligature risk assessment include mitigating actions for all ligature risks and all staff have access to a hard copy of the most up to date ligature risk assessment.
- The provider must ensure that all equipment is regularly serviced, have visible testing stickers and that staff have access to the service history for all equipment.
- The provider must ensure that all emergency equipment is checked regularly, and that emergency equipment is placed on charge.
- The service must ensure that wards have access to replacement oxygen cylinders.
- The provider must ensure that patients and carers are fully involved in care planning and incident reviews.
- The provider must ensure that staff do not talk in languages other than English when in front of patients.
- The provider must ensure that care and treatment is patient centred and that plans fully address gender issues.
- The provider must ensure that staff are fully aware of how the visions and values impact on their day to day work role.

Action the service SHOULD take to improve:

- The service should ensure that all patients have duvets on their beds.
- The service should ensure that staff who are new into managerial roles are fully supported and have the necessary skills to undertake the role.
- The service should ensure that patients and their families are fully involved in incident investigations.

The service should ensure that improvements in their governance processes continue to be developed and embedded, so they are clear and avoid duplication.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Not inspected	Requires Improvement	Not inspected	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Not inspected	Requires Improvement	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Requires Improvement	Not inspected	Requires Improvement	Requires Improvement

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

Requires Improvement

Safe	Requires Improvement
Caring	Requires Improvement
Well-led	Requires Improvement

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

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff had completed and regularly updated thorough risk assessments of the wards area. However, we noted that curtain rails had been screwed to the wall, and that mitigating actions had not been identified for this risk. We raised this concern with the provider at the time of our inspection. Staff knew about most potential ligature anchor points and mitigated the risks to keep patients safe. However, staff on the ward did not have access to a hard copy of the most up to date ligature risk assessment for the ward. The copy on the ward was out of date, however, staff could access this electronically.

Staff could observe patients in most parts of the wards. Staff had access to closed circuit television and mirrors to mitigate any areas which they were unable to observe. However, closed circuit television was not identified as a mitigating factor on the ligature risk assessment documentation.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. However, we were informed that the alarm system was not always reliable. One staff member informed us that the staff call alarm did not always activate.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. However, there was no documentation available to evidence that some medical equipment, a standing frame, turn table and mattress pump had been serviced. Some medical equipment did not have portable electrical testing stickers visible.

Staff made sure cleaning records were up-to-date and that the premises were clean.

Staff followed infection control policy, including handwashing. However, staff had not made masks or hand sanitiser available outside the bedroom of a patient who was in isolation. We gave feedback to the provider and the issue was addressed immediately.

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

Requires Improvement

Clinic room and equipment

Clinic rooms were fully equipped, clean and well stocked and emergency drugs that staff checked regularly. Resuscitation equipment was available which was in date and had been checked regularly. All staff were not aware that resuscitation equipment was available on each floor.

Staff had fully checked, maintained, and cleaned equipment. We were not able to find evidence that a standing frame, turn table and mattress pump had been serviced. Staff had not ensured that equipment had stickers to identify when equipment had been serviced.

Safe staffing

The service generally had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe throughout the week. The provider had ensured that there were two registered nurses on each shift and seven carers. A new electronic rota system had been in place. This prevented staff booking shifts based on personal preference and the rotas were now based on clinical need. However, one member of staff reported that staffing levels at the weekend were low, due to staff self-rostering. The provider submitted figures which showed staffing was not short at weekends.

The service had reducing vacancy rates for nursing staff. However, the hospital had three vacancies for occupational therapists. Cover was provided for these vacancies by occupational therapists from other locations in the St Matthews Hospital group.

The service had low and reducing rates of bank and agency nurses and nursing assistants. Across the hospital, we noted that there had been almost a three percent reduction in agency use from (17.2%) May 2021 to (14.4%) in July 2021.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service used agency and bank staff who had worked on the ward for a considerable length of time.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had reducing turnover rates. The turnover rate across the hospital between July (7.4%) and September 2021 (4.7%) had reduced by almost three percent.

Managers supported staff who needed time off for ill health. Levels of sickness for the hospital were low and reducing. The sickness level had reduced across the hospital by one percent between June and October 2021from 2.7% to 1.6%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. A physical healthcare lead was now in post and had set up effective monitoring of all physical healthcare needs of patients.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. One consultant psychiatrist and an associate specialist provided medical cover to both Holdenby ward and another ward (Manor) at Broomhill.

Mandatory training

Staff had completed and kept up to date with their mandatory training. This was an improved picture since our last inspection. The mandatory training rate across the hospital for permanent and block booked agency staff was 94% at the time of inspection.

The mandatory training programme was comprehensive and met the needs of patients and staff. This now included training on specific acute mental health topics and conditions.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. The service had an improved plan for reducing restrictive interventions.

Assessment of patient risk

Staff had completed risk assessments for each patient on admission, using a recognised tool. We reviewed four patient records (67%), all of these had been reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool. All identified risks included a risk rating indicating the level of severity.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. The provider undertook daily checks to ensure that patient observations had been fully completed and recorded in line with the provider's policy. Recording of patient observations had improved. The service carried out audits of observation recordings and managers gave feedback to staff on the audit results.

Staff had identified and responded to any changes in risks to, or posed by, patients. Staff updated risk assessments after incidents and incident numbers were recorded in daily clinical summaries on most occasions.

Staff could observe patients in most areas of the ward and staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

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

Requires Improvement

Levels of restrictive interventions were low and there had been a marked reduction in the use of restrictive intervention. The service had improved their approach to reviewing restrictive interventions since our last inspection. The service participated in 'no' audits which looked to identify and reduce any ways that staff micromanaged patients' behaviours and applied restrictive interventions by instantly using the word 'no' to patients' requests.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

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

Staff followed NICE guidance when using rapid tranquilisation. Staff carried out observations of patients and recorded this effectively.

Safeguarding

We noted improvement in safeguarding practices at the service. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All registered staff received level three safeguarding training delivered in a classroom setting. The provider had held a safeguarding convention, and training was available online. In addition, the provider had appointed a new safeguarding lead, who supported staff on the wards.

Staff had kept up to date with their safeguarding training. At the time of our inspection, the training figures for safeguarding across the hospital wards was 93%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Deputy ward managers took part in investigations where necessary.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff had access to electronic devices to record key patient information in the electronic note system.

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

Requires Improvement

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. This had improved since our last inspection. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems in place via an external pharmacy provider, to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

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

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. This included monitoring patients for effects of rapid tranquilisation when used.

Track record on safety

The service had an improved track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. We reviewed four incident reports which were fully completed. However, there was no daily entry relating to one of the incidents in the patient's daily record.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Staff reported incidents clearly and in line with the provider's policy

The service understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw investigation reports that included apologies.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. However, we were unable to find evidence that the patients and their families were involved in these investigations.

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

Requires Improvement

Staff received feedback from investigation of incidents. We found learning alert bulletins displayed on the ward. Staff told us that learning had also been shared via e-mails and meetings.

Staff met to discuss the feedback and look at improvements to patient care. Daily huddles and flash meeting took place twice daily.

There was evidence that changes had been made as a result of feedback. We noted that agency staff now receive supervision and medication management training further to a reported incident.

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

Requires Improvement

Our rating of caring improved. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff mostly treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Most of the staff were discreet, respectful, and responsive when caring for patients. However, one patient told us that some staff had made her feel 'like a second-class citizen on the ward. Another patient told us that they had heard staffing mock a patient behind their back, adding that staff had laughed about the patient'.

Some staff had given patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition

Patients said most staff had treated them well and behaved kindly. One patient told us that 'the majority of staff on the ward were kind'.

Staff mostly understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff had not fully involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

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

Requires Improvement

Staff had not fully involved patients and given them access to their care planning and risk assessments. We saw evidence that some patients had been invited to comment on their care plan. However, four care plans were written in the third person, and not from the patient's perspective.

Staff had not always made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff had not involved patients in decisions about the service, when appropriate. However, directors we spoke to said there had been so many improvements to focus on, they needed to prioritise improvements. Directors told us they had plans to ask patients to involved in various committees and meetings about the service in the future.

Patients could give feedback on the service and their treatment and staff supported them to do this. We saw suggestion boxes on every ward which encouraged patients to give their views on the service.

Staff supported most patients to make advanced decisions on their care. This was incorporated in the patients' risk assessment and risk management plans.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff had not always fully informed and involved families and carers appropriately.

We found that staff had not always supported, informed and involved families or carers. Staff told us that patient's carers are not currently invited to attend ward rounds.

Staff helped families to give feedback on the service.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Executive directors had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. The hospital had invested in a deputy ward manager for each ward to lead each ward team.

Since our last inspection, the executive leadership team had revised the portfolios of directors. Several new posts had been created, including a director of operations and a director of finance (these roles had been separated out from a previous role which combined finance, procurement and commissioning) and an associate director of nursing to support the director of nursing and clinical services. Two non-executive directors had been appointed with backgrounds in healthcare and industry and had experience of corporate governance.

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

Requires Improvement

Each director was responsible for specific areas of governance. This meant there was clarity for who was responsible for reporting on performance. Every ward had a television screen which showed who was who in the senior leadership team and most staff told us they knew who the senor leaders were. Staff told us senior leaders carried out walk rounds of each ward and we saw evidence in meeting minutes of the walk arounds and action leaders had taken about issues staff had raised with them. Qualified staff and health care workers told us they found senior leaders of the hospital approachable and they would feel happy, in most cases, to raise issues directly with certain directors.

Leaders had invested in deputy ward managers for each ward. There were twice daily huddle meetings chaired by the registered manager. All deputy managers attended, and a handover took place where incidents were discussed from the day before, staffing levels were reviewed, and patients' needs were discussed. Jobs for the day were also highlighted. We observed one manager gave positive feedback to the staff about results from an audit of observation records. Staff told us they had appreciated the positive feedback.

Since our last inspection, new posts had been created, including a freedom to speak up guardian, a safeguarding lead, which was a specific role and not an add on to an existing role; a physical healthcare lead was new into post in May 2021.

A deputy ward manager had been in post in an acting role since July 2021 on Holdenby ward and had been supported by a colleague to carry out their role.

Vision and strategy

Not all staff knew and understood the provider's vision and values. However, senior leaders at director level had worked hard to promote the hospital's values they expected staff to meet.

Since our last inspection, the hospital directors had produced posters for the wards to describe the hospital's visions and values. The posters were in communal areas of the ward and staff knew they were there but could not easily describe what the detail in the poster was. However, staff were clearly able to describe what their managers expected of them at work. This included being kind and caring, and that managers had worked hard to ensure the right staff were employed to care for patients.

Directors told us they had regular strategy meetings to discuss how they could improve their vision and strategy. Discussions had taken place to develop a new vision which included revised values that would be easy for staff to understand how to apply them to their everyday roles. The strategy discussions included clinical models to develop, introduce and embed. The new revised strategy would be used to shape the services in the next five years. The directors of the service were joined up in their thinking and we saw minutes of meetings where planning for a more developed future strategy had taken place.

Culture

Senior managers had made significant steps to improve the staff culture at the hospital. Staff told us that morale had improved and managers had taken action when poor performance and attitude had been identified.

Directors had delivered a number of conferences, training sessions and had set up meetings where they told staff about the behaviours they expected from their workforce. Directors had committed to address the behaviour of staff which did not show kindness, promote diversity or care for patients in a compassionate way. Leaders of the hospital had invested in new roles to help improve the culture. This included a Freedom to Speak Up Guardian, and a safeguarding lead, both with training to a level recommended by national guidance. Senior managers had delivered training sessions to staff to

improve awareness of how to speak up and raise concerns and had appointed six Freedom to Speak Up champions at ward level across a variety of disciplines. Speak up incidents had increased quarter by quarter at the hospital, with a total of 16 speak up issues. The senior managers saw this as a positive step towards staff feeling confident to raise issues.

Staff awareness of safeguarding processes and actions they were required to take had improved. Senior leaders of the organisation had worked with local stakeholders to deliver training sessions to staff on safeguarding; which included a conference, drop-in sessions, newsletters and training session. This worked had impacted staff as most had improved awareness of what to do if they needed to report an incident and take action to protect patients.

Action by senior managers to manage poor performance was much improved. A head of human resources had been appointed and in post since June 2021 and had worked with directors to review arrangements for use of agencies which supplied agency staff at the hospital. Checks of agency staff were improved and training of agency staff was combined with training of permanent staff to ensure consistency. There were three ongoing cases requiring investigation in connection to poor performance at the time of our inspection, with eight cases closed, two of which had resulted in disciplinary action, three with action plans to monitor performance and two resignations following investigation.

A combination of investment of human resources, Freedom to Speak Up roles, a safeguarding lead and ownership by directors and senior leaders to develop a positive culture had impacted the atmosphere of the hospital. Staff we spoke with were positive about changes they had seen implemented and told us the hospital was a better place to work.

Governance

Governance at all levels in the hospital had been revised and improved. New more robust processes to audit performance and risk had been implemented. Governance processes from ward to board and board to ward were in place.

Directors of the hospital had made significant changes to their governance processes and reporting structures. Each director had a portfolio of responsibilities for which they were accountable to board. Below director level, senior leaders and heads of department reported into directors. Below senior leader level and heads of department, deputy ward managers were accountable for ward performance. However, some deputy ward mangers were new into post and not all ward managers could clearly articulate the current performance of their wards. Guidance and shadowing opportunities had been made available to staff in new leadership roles.

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

Requires Improvement

Staff on the wards told us they knew how to escalate issues. Staff felt confident that senior managers responded to issues raised and staff had received feedback on action taken. We saw team briefings and learning alerts that capture "you said we did" feedback.

Management of risk, issues and performance

Directors had developed new systems for monitoring performance and risk across the hospital. Most ward managers had access to the information they needed to oversee performance.

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Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Requires Improvement
Caring	Requires Improvement
Well-led	Requires Improvement

Are Long stay or rehabilitation mental health wards for working age adults safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough ligature risk assessments of all wards areas and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligature risk assessments were stored electronically. However, staff could not locate the most up to date version and there was not a hard copy available on Althorp ward.

Staff could observe patients in all parts of the wards. Staff had access to closed circuit television and mirrors to mitigate any areas which they were unable to observe. However, closed circuit television was not identified as a mitigating factor on the ligature risk assessment documentation.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. However, we found that three patient beds did not have duvet covers.

Staff followed infection prevention and control measures on the wards and in communal areas, and specifically followed guidance in relation to COVID-19.

Clinic room and equipment

Clinic rooms were fully equipped, clean and had accessible resuscitation equipment and emergency drugs.

We found the emergency bag on Kelmarsh ward had not been checked regularly. Staff had not fully checked, maintained, and cleaned emergency equipment. The emergency bag on Spencer ward had out of date defibrillation

pads. in one emergency bag, which had not been checked by staff. We found that one suction machine had not been plugged in and was therefore not charged. We told the provider about these issues and they rectified them immediately. Despite clinical governance meeting minutes which recorded that audits of emergency equipment had been completed and items restocked we did not find this to be the case on inspection.

The provider had not ensured that spare oxygen cylinders were available. All staff we spoke with were not aware that resuscitation equipment or oxygen was available on each floor of the hospital, despite clear posters in communal areas of the wards and hospitals showing locations of all emergency equipment and oxygen.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Staffing had improved since our last inspection. The service had enough nursing and support staff to keep patients safe. A new electronic rota system had been in place. This prevented staff booking shifts based on personal preference and the rotas were now based on clinical need. However, on one ward we inspected in the afternoon; a nurse had not had a break since commencing duty at 07:30 hours.

The service had reducing vacancy rates for nursing staff. However, the hospital had three vacancies for occupational therapists. Cover was provided for these vacancies by occupational therapists from other locations in the St Matthews Hospital group.

The service had low and reducing rates of bank and agency nurses and nursing assistants. Across the hospital, we noted that there had been almost a three percent reduction in agency use from (17.2%) May 2021 to (14.4%) in July 2021.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service used agency and bank staff who had worked on the ward for a considerable length of time and block booked them in advance where possible.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had reducing turnover rates. The turnover rate across the hospital between July (7.4%) and September 2021 (4.7%) had reduced by almost three percent.

Managers supported staff who needed time off for ill health. Levels of sickness for the hospital were low and reducing. The sickness level had reduced across the hospital by one percent between June and October 2021from 2.7% to 1.6%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. There were activity coordinators who worked on the wards.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients had regular one-to-one sessions with their named nurse. Staff planned regular on-to-one sessions and supported patients with adhoc sessions following incidents and when a patient requested one.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had enough staff on each shift to carry out any physical interventions safely. A physical healthcare lead was now in post and had set up effective monitoring of all physical healthcare needs of patients.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Staff could access locum medical cover in the absence of their permanent medical staff.

Mandatory training

Staff had completed and kept up to date with their mandatory training. This was an improved picture since our last inspection. The mandatory training rate across the hospital for permanent and block booked agency staff was 94% at the time of inspection.

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. The service had an improved plan for reducing restrictive interventions.

Assessment of patient risk

Staff had completed risk assessments for each patient on admission, using a recognised tool. We reviewed 16 patient records all of these had been reviewed regularly, including after any incident.

Staff used a recognised risk assessment tool. All identified risks included a risk rating indicating the level of severity.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. The provider undertook daily checks to ensure that patient observations had been fully completed and recorded in line with the provider's policy. Recording of patient observations had improved. The service carried out audits of observation recordings and managers gave feedback to staff on the audit results.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff updated risk assessments after incidents and incident numbers were recorded in daily clinical summaries on most occasions.

Staff could observe patients in all areas, and staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low and were reducing.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had improved their approach to reviewing restrictive interventions since our last inspection. The service participated in 'no' audits which looked to identify and reduce any ways that staff micromanaged patients' behaviours and applied restrictive interventions by instantly using the word 'no' to patients' requests.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

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

Staff followed NICE guidance when using rapid tranquilisation. Staff carried out observations of patients and recorded this effectively.

Safeguarding

We noted improvement in safeguarding practices at the service. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role and now in line with national guidance. All registered staff received level three safeguarding training delivered in a classroom setting. The provider had held a safeguarding convention delivered in collaboration with the local authority, and training was available online. In addition, the provider had appointed a new safeguarding lead, who supported staff on the wards. The safeguarding lead delivered safeguarding workshops to the wards based on their requests or any areas identified for strengthening through observation of their practice of their participation in training. Staff had access to safeguarding drop in surgeries to ask questions and seek support.

Staff had kept up to date with their safeguarding training. At the time of our inspection, the training figures for safeguarding across the hospital wards was 93%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

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

However, not all staff were aware of how to make a safeguarding referral; however, they knew who to inform if they had concerns and were confident a safeguarding referral would be made by the service.

Deputy ward managers took part in investigations where necessary.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Records were stored securely. Staff had access to electronic devices to record key patient information in the electronic note system.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. This had improved since our last inspection. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

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

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

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. This included monitoring patients for effects of rapid tranquilisation when used.

Track record on safety

The service had an improved track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. We reviewed 23 incident reports which were fully completed.

Staff reported incidents clearly and in line with the providers' policy.

The service understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw investigation reports that included apologies.

Managers provided debriefs and supported staff after incidents.

Managers investigated incidents thoroughly. However, the service did not evidence how they involved patients' families in these investigations.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff received feedback from investigation of incidents. The service displayed learning alerts on the ward and in communal areas. Staff told us that learning had also been shared via e-mails and meetings and huddles.

Staff met to discuss the feedback and look at improvements to patient care. Daily huddles and flash meetings took place twice daily.

There was evidence that changes had been made as a result of feedback. Agency staff now received supervision and improved training; safeguarding training for staff had improved, and the service provided further medication management training following a reported incident. A physical healthcare nurse was in post and had oversight of every patient's physical healthcare needs.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Requires Improvement

Our rating of caring improved. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness on most occasions. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were mostly discreet, respectful, and responsive when caring for patients. At this inspection, we noted that the frequency of reports of staff speaking in languages other than English had reduced significantly. Senior managers had worked to delivered training and had given a clear message to staff that English was the language of the organisation. Staff received supervision or underwent formal performance management if it was highlighted, they had used a language other than English in front of patients. However, three patients reported that they had recently heard staff talking in languages other than English recently. Two of the three patients reported that staff had been talking in other languages the previous night and the third patient stated that they had hear this 'the other day'.

Staff supported patients to understand and manage their own care treatment or condition. However, in three bedrooms, patients did not have duvet covers on their duvets. One patient told us the duvet cover did not have fasteners and so slipped off. The provider told us the duvets were washed but would include duvet cover checks in their audits of bedding. The provider told us they would consider using a new supplier for their duvet covers.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said most staff treated them well and behaved kindly. However, one patient told us that staff were 'unpleasant and unfriendly'.

Staff generally understood and respected the individual needs of each patient. However, we found that staff had not always responded in a way which fully considered patients gender identity. This was highlighted to staff, who had responded to our concerns by the following day.

At this inspection, staff felt more confident that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes of other staff towards patients.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed policy to keep patient information confidential.

Involvement in care

Staff did not fully involve patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff had not fully involved all patients and given them access to their care planning and risk assessments. We saw evidence that some patients had been invited to comment on their care plan. However, all 16 care plans we reviewed were written in the third person, and not from the patient's perspective.

Staff had completed care plans with patients and had indicated patients had been involved with care plans. Half of the care plans indicated patients had been involved. Staff had not always made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff had not involved patients in decisions about the service, when appropriate. However, directors we spoke to said there had been so many improvements to focus on, they needed to prioritise improvements. Directors told us they had plans to ask patients to involved in various committees and meetings about the service in the future.

Patients could give feedback on the service and their treatment and staff supported them to do this. We saw suggestion boxes on every ward which encouraged patients to give their views on the service.

Staff supported most patients to make advanced decisions on their care. This was incorporated in the patients' risk assessment and risk management plans.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff had not always fully informed and involved families and carers appropriately.

We found that staff had not always supported, informed, and involved families or carers. Staff did not currently invite patient's carers to ward rounds.

Staff helped families to give feedback on the service.

One carer told us they had asked the provider about therapies that were provided and felt there was not enough activity on Althorp ward.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Leadership

Executive directors had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. The hospital had invested in a deputy ward manager for each ward to lead each ward team.

Since our last inspection, the executive leadership team had revised the portfolios of directors. Several new posts had been created, including a director of operations and a director of finance (these roles had been separated out from a previous role which combined finance, procurement and commissioning) and an associate director of nursing to support the director of nursing and clinical services. Two non-executive directors had been appointed with backgrounds in healthcare and industry and had experience of corporate governance.

Each director was responsible for specific areas of governance. This meant there was clarity for who was responsible for reporting on performance. Every ward had a television screen which showed who was who in the senior leadership team and most staff told us they knew who the senor leaders were. Staff told us senior leaders carried out walk rounds of each ward and we saw evidence in meeting minutes of the walk arounds and action leaders had taken about issues staff had raised with them. Qualified staff and health care workers told us they found senior leaders of the hospital approachable and they would feel happy, in most cases, to raise issues directly with certain directors.

Leaders had invested in deputy ward managers for each ward. There were twice daily huddle meetings chaired by the registered manager. All deputy managers attended, and a handover took place where incidents were discussed from the day before, staffing levels were reviewed, and patients' needs were discussed. Jobs for the day were also highlighted. We observed one manager gave positive feedback to the staff about results from an audit of observation records. Staff told us they had appreciated the positive feedback.

Since our last inspection, new posts had been created, including a freedom to speak up guardian, a safeguarding lead, which was a specific role and not an add on to an existing role; a physical healthcare lead was new into post in May 2021.

Vision and strategy

Not all staff knew and understood the provider's vision and values. However, senior leaders at director level had worked hard to promote the hospital's values they expected staff to meet.

Since our last inspection, the hospital directors had produced posters for the wards to describe the hospital's visions and values. The posters were in communal areas of the ward and staff knew they were there but could not easily describe what the detail in the poster was. However, staff were clearly able to describe what their managers expected of them at work. This included being kind and caring, and that managers had worked hard to ensure the right staff were employed to care for patients.

Directors told us they had regular strategy meetings to discuss how they could improve their vision and strategy. Discussions had taken place to develop a new vision which included revised values that would be easy for staff to understand how to apply them to their everyday roles. The strategy discussions included clinical models to develop, introduce and embed. The new revised strategy would be used to shape the services in the next five years. The directors of the service were joined up in their thinking and we saw minutes of meetings where planning for a more developed future strategy had taken place.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Culture

Senior managers had made significant steps to improve the staff culture at the hospital. Staff told us that morale had improved and managers had taken action when poor performance and attitude had been identified.

Directors had delivered a number of conferences, training sessions and had set up meetings where they told staff about the behaviours they expected from their workforce. Directors had committed to address the behaviour of staff which did not show kindness, promote diversity or care for patients in a compassionate way. Leaders of the hospital had invested in new roles to help improve the culture. This included a Freedom to Speak Up Guardian, and a safeguarding lead, both with training to a level recommended by national guidance. Senior managers had delivered training sessions to staff to improve awareness of how to speak up and raise concerns and had appointed six Freedom to Speak Up champions at ward level across a variety of disciplines. Speak up incidents had increased quarter by quarter at the hospital, with a total of 16 speak up issues. The senior managers saw this as a positive step towards staff feeling confident to raise issues.

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Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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Directors told us they had undergone a period of intense reflection of the issues raised from previous inspections. Directors acknowledged the need to improve and engage in continuous improvement. At this inspection, we saw evidence of a step change in how directors delivered changes to governance, management of risk, and clinical care. The minutes of governance committees, feedback from director ward visits, dashboards and key performance indicators demonstrated an appetite for service improvement and learning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Not all staff across the hospital knew and understood the provider's vision and values.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Staff had not written all patient care plans from the patient's perspective. • In both services, patients had not been fully involved in the development of their care plans. Half of records seen did not indicate patients had been involved in the development of their care plans.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Emergency response equipment had out of date items or uncharged items, had not been checked by staff and spare oxygen cylinders were not available. Not all staff knew where oxygen cylinders were located. • Ligature risk assessments in two wards were not accessible to staff. Some ligature risks did not have full mitigation documented to manage the risk. The installation of closed circuit television had not been included as mitigation on nay risk assessments.

This section is primarily information for the provider

Requirement notices

- The service did not evidence that some medical equipment had been serviced and service stickers were not in place on some equipment to show it had been tested.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Not all staff had been respectful and caring when caring for patients. Three patients reported hearing languages not English . One patient overheard staff mocking; One patient felt like a second class citizen. • Staff had not responded appropriately to patients' gender issues.