Kneesworth House

Quality Report

Kneesworth House Hospital
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We did not rate forensic/secure wards or psychiatric intensive care units at this focused inspection. We carried out this inspection to look at what improvements the provider had made after the concerns raised by the focused inspection on 23-25 June 2019, after which the CQC imposed urgent conditions on the provider. This inspection focused solely on the progress made against the conditions imposed by the Care Quality Commission across two core services. The report reflects what we found in the three wards we inspected. These were:

- Ermine ward, a 19-bed medium secure service for men with a mental illness
- Orwell ward, a 18-bed low secure service for men with a mental illness
- Wimpole ward, a 12-bed psychiatric intensive care unit for women with a mental illness

We found the following issues that the provider needs to improve:

- Managers had not transferred the learning from problems identified on the PICU to the rest of the hospital site. There were significant environmental issues on Ermine and Orwell wards, including dirty toilets, damage to the environment and a dirty kitchen area.
- The service had not ensured they had met all the conditions imposed by the CQC. Staff in the forensic/secure wards had not reviewed all patients' risk assessments weekly as required and there had been considerable delays in completing some of the actions identified in their own action plan.
- In the forensic service, staff undertook constant and intermittent observations for more than two hours without a break, which was not in line with their own policy and best practice. Managers had not maintained oversight of this.
- Staff on the PICU did not always categorise the severity of incidents appropriately on the provider's electronic incident recording system. Staff had classified some incidents of self-harming behaviour, including head banging, tying ligatures and assaults against staff, as having no harm or impact.
- Managers had not provided clarity about how staffing levels on the PICU should increase in response to patient numbers.
- The Priory's mandatory ligature risk audit document did not allow staff to specify the nature of the risk effectively.

However, we found the following areas of good practice:

Summary of findings

- The service had addressed the environmental issues on the PICU and had systems in place to ensure the ward remained clean and safe.
- Senior managers and ward managers had ensured staff on Wimpole ward had PICU specific training, including risk assessment and risk management, and were adequately prepared to work with patients within the service.
- Senior managers had increased staffing levels on Ermine and Orwell wards to ensure there were enough staff to maintain the safety of patients and facilitate patient leave consistently.
- Ward managers had ensured up-to-date ligature risk assessments were easily available to staff.

Summary of findings

Contents

Kneesworth House

Services we looked at
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards;

Summary of this inspection

Background to Kneesworth House

Kneesworth House is part of the Priory Group of companies. It provides inpatient care for people with acute mental health problems, a psychiatric intensive care unit (PICU), locked and open rehabilitation services, and medium and low secure forensic services for people with enduring mental health problems.

The service is registered to provide the following regulated activities:

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

The hospital has 140 beds. Since the last comprehensive inspection, the provider has closed Icknield ward, a 16-bed low secure service for men with a mental illness and learning disability and opened Wimpole ward a psychiatric intensive care unit (PICU) for women.

The Care Quality Commission last completed a comprehensive inspection of this location between 19 February and 4 April 2019. Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. Requirement notices were issues under the following regulations:

- Regulation 9 – Person-centred care
- Regulation 10 – Dignity and respect
- Regulation 12 – Safe care and treatment
- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 15 – Premises and equipment
- Regulation 17 – Good governance
- Regulation 18 – Staffing

The overall rating for this location was inadequate, with inadequate in the safe, caring and well led domains and good for effective and responsive. The report for this inspection was published in July 2019. As a result of these concerns, the hospital was placed in special measures.

We also inspected the hospital in June 2019 to consider what improvement if any the hospital had made. We found significant concerns about some forensic wards and the newly opened psychiatric intensive care unit, Wimpole ward and told the provider that they must:

- undertake a review of cleaning and infection control practices, including the cleaning schedules at the PICU, to ensure that this is sufficient to ensure the care environments are clean and odour free.
- undertake a review of the environment of the PICU to include ligature risks within the ward and service users' privacy, dignity and safety from risk when in their bedrooms.
- undertake a review of the environment of the PICU to ensure dining room and bedroom floors, taps and waste traps are in good condition and replaced where appropriate, and that the environment is well maintained.
- ensure that all patients have a risk assessment in place which identifies patients' risks, enables staff to manage those risks and is updated after incidents.
- ensure that there is a review of staffing on the PICU to assure themselves the staff on the PICU are suitably qualified and competent to carry out their roles in a PICU environment and are trained in the identification and management of clinical risk.
- ensure that there are sufficient staff, who are experienced and appropriately trained to ensure a safe and therapeutic environment for patients.
- ensure that seclusion is carried out in line with the requirements of the Mental Health Act Code of Practice and that records are completed and stored appropriately.

Following this inspection, we took urgent enforcement action and placed conditions on the provider's registration. This report was published in September 2019. Since, we have continued to monitor the service including an additional inspection in August 2019. This report was also published in September 2019.

This inspection took place throughout October 2019. This was a focused inspection to consider the areas for which we took enforcement action. This inspection was not rated.

Summary of this inspection

We inspected the following wards:

Forensic inpatient/secure wards

- Ermine - 19 bed medium secure service for men with a mental illness.
- Orwell - 18 bed low secure service for men with a mental illness.

Psychiatric intensive care unit

Wimpole ward – 12-bed service for women with a mental illness.

Our inspection team

The team that inspected the service comprised three CQC inspectors, one CQC inspection manager and two specialist advisors.

Why we carried out this inspection

We carried out this inspection to look at what improvements the provider had made after the concerns raised by the focused inspection on 23-25 June 2019 which led to an urgent Notice of Decision to impose conditions on the provider. This inspection focused solely at the progress made against the conditions imposed by the Care Quality Commission.

How we carried out this inspection

Before the inspection visit, we reviewed information the provider had sent us about the actions they had taken. At the inspection we reviewed the breaches that led to CQC imposing urgent conditions on the provider. The inspection focused on the safe and well-led domains.

During the inspection visit, the inspection team:

- visited three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with four patients who were using the service;
- spoke with the registered manager, service managers and managers or acting managers for each of the wards;
- spoke with 14 other staff members; including doctors, nurses, healthcare assistants therapy assistants;
- looked at 17 care and treatment records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with four patients. Patients on the forensic wards told us that there were enough staff on the ward and that they felt safe. They said this had improved over the past few months. Patients said that staff were helpful and kind.

Patients on the PICU told us staff were helpful and supportive and that there were things to do on the ward.

We looked at care plans for 17 patients which all showed clear evidence of patient involvement, including some written in the patient's own words.

We observed staff treating patients with compassion and kindness. Staff engaged with patients throughout the day and participated in activities such as playing cards and cooking. We observed staff supporting patients and trying to resolve issues raised by the patient.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues that the provider needs to improve:

- There were significant environmental issues on the forensic wards. These included dirty toilets, damage to the environment and a dirty kitchen area. Some fridges were damaged, and staff had not recorded fridge temperatures consistently.
- In the forensic service, staff had not undertaken a weekly review of all service users' risk assessments, nursing assessments, associated care plans and positive behaviour support plans as detailed in the CQC's conditions and the provider's action plan.
- In the forensic service, staff undertook constant and intermittent observations for more than two hours without a break, which was not in line with their own policy and best practice.
- Staff on the PICU did not always categorise the severity of incidents appropriately on the provider's electronic incident recording system. Staff had classified some incidents of self-harming behaviour, including head banging, tying ligatures and assaults against staff, as having no harm or impact.

However, we found the following areas of good practice:

- The ward environment was safe and clean on the psychiatric intensive care unit (PICU). The provider had addressed the majority of the environment concerns raised at the inspection in June 2019. The ward was clean and sink wastes had been replaced in bathrooms, shower rooms and bedrooms. The dining room and kitchen floors had been replaced and the ward redecorated.
- The PICU had enough nursing and medical staff for the limited number of patients on the ward, who knew the patients and received basic training to keep patients safe from avoidable harm. The forensic/secure wards, which were designed over two floors, deployed enough staff to maintain the safety of patients and facilitate patient leave consistently. Staff had minimised the use of restrictive practices on these wards by increasing staffing levels.
- All patients on the PICU had risk assessments in place which staff reviewed regularly including after incidents.
- Staff had easy access to ligature risk audits for all the wards and staff knew where to find them. Paper copies were the most up-to-date version available.

Summary of this inspection

Are services well-led?

We found the following issues that the provider needs to improve:

- Managers had not transferred the learning from problems identified on the PICU to the rest of the hospital site. The same issues identified on the PICU remained issues across the forensic/secure service.
- The service had not ensured they had met all the conditions imposed by the CQC. Staff in the forensic/secure wards had not reviewed all patients' risk assessments weekly and there had been considerable delays in completing some of the actions identified in their own action plan.
- Managers had not provided clarity about how staffing levels on the PICU should increase in response to patient numbers.
- Managers had not maintained oversight of the observation practices on the secure wards.
- The Priory's mandatory ligature risk audit document did not allow staff to specify the nature of the risk effectively.

However, we found the following areas of good practice:

- Senior managers had increased staffing levels on Ermine and Orwell wards to ensure there were enough staff to maintain the safety of patients and facilitate patient leave consistently.
- Ward managers had ensured up-to-date ligature risk assessments were easily available to staff.
- The service had addressed the environmental issues on the PICU and had systems in place to ensure the ward remained clean and safe.
- Senior managers and ward managers had ensured staff on Wimpole ward had PICU specific training, including risk assessment and risk management, and were adequately prepared to work with patients within the service.

Forensic inpatient or secure wards

Safe	
Well-led	

Are forensic inpatient or secure wards safe?

This inspection was a focused inspection across two core services. The report reflects what we found in the three wards we inspected. These were:

- Ermine ward, a 19-bed medium secure service for men with a mental illness
- Orwell ward, a 18-bed low secure service for men with a mental illness
- Wimpole ward, a 12-bed psychiatric intensive care unit for women with a mental illness

Safe and clean environment

- Wimpole ward was opened in April 2019 and catered for up to twelve patients. Bedrooms were not en-suite and patients had to share toilet and shower facilities. When we visited in June 2019, the PICU was dirty and poorly maintained. We had concerns about facilities within toilet and bathroom areas and the cleanliness of the kitchen, dining room and bathrooms. We also had concerns about food storage arrangements.
- The provider produced an action plan to address the issues identified but did not complete the work in accordance with their own timescales. They had resolved some of these issues when we inspected again on 1 August 2019. Kitchen, dining room and communal areas were much cleaner, and some maintenance had taken place. However, we still had concerns in relation to the sink and shower drains, the dining room and kitchen floors and the chiller cabinet which was giving fluctuating temperature readings. This was due for completion on 31 July 2019.
- When we inspected on 3 October 2019, the seclusion room, dining room, kitchen and some of the empty bedrooms were not in use and were being renovated. New floors were being laid in the kitchen and dining room and maintenance staff were making some significant improvements to the seclusion room.
- Ward areas were clean and well maintained when we inspected on 22 and 23 October 2019. Housekeeping staff cleaned the ward daily and nursing staff completed additional cleaning when needed. The provider had replaced the dining room and kitchen floors, the seclusion room was operational, and had fitted new sink wastes to bathrooms, shower rooms and patient bedrooms. Furniture was well-maintained, and the ward décor was of a good standard. The kitchen and dining room were clean, including the servery area. The chiller cabinet had been tested and the temperature readout rectified. However, staff did not regularly test the temperature of the chiller to ensure the readings on the display were correct.
- There were several significant maintenance issues on the forensic wards. On Orwell ward, two toilets were stained and the floors surrounding the toilets were dirty. The bathroom floor in one of the upstairs bathrooms was dirty and, when we visited on 23 October, the water supply to most of the bathrooms had failed, meaning that toilet waste could not be flushed away. We raised this with the provider who addressed this. The baths were marked where bathmats, previously stuck down on the bath, had come away. The bathroom floor in the seclusion room was marked. The dining room furniture was well worn, and the manager told us this was in the process of being replaced. The kitchen was dirty, particularly under the dishwasher and in the cleaning cupboard. There was a build-up of ice at the back of the fridge compartment of the fridge-freezer and the top drawer of the freezer compartment was broken and contained a large block of ice. Staff completed fridge recording for the two fridges in the dining room and kitchen areas on the same sheet; it was difficult to determine which each recording related to and contained significant gaps. Staff had not recorded fridge temperatures for the fridge in the main ward area. There was a strong smell in the upstairs bedroom area. However, some of the ward areas were clean and well furnished. The provider had fitted a new floor in the quiet room and redecorated the downstairs areas.
- On Ermine ward, there was a strong smell in the seclusion room and the door surrounds for two bedrooms were damaged. In the communal ward area downstairs, the television screen cover was heavily scratched. Staff had not recorded temperatures for the

fridge used for patients' drinks downstairs and the drinks dispenser upstairs was dirty around the base. However, the provider had replaced the broken telephone, noted at the last inspection, with a phone linked to the office telephone. This did not present a ligature risk to patients.

- We raised these issues with the provider who took steps to resolve some of the concerns. The provider also told us of plans to renovate and redesign the forensic/secure wards to improve the environmental issues across the site.
- Ligature risk audits were easily available to staff across all the wards we visited and were the most up-to-date version. Ligature is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Managers told us that they were in the process of reviewing ligature audits for all the wards. Thirteen of the 14 nursing staff we spoke with knew where to find them. However, one member of staff on Ermine ward knew about the risk audit but had not seen it and was unsure where it was located.
- When we visited the PICU in June 2019, staff did not have easy access to up-to-date ligature risk assessments and some staff did not know where to find them. We noted some improvements when we inspected on 1 August 2019 although staff had not included all risks in the risk audit, for example in the courtyard.
- When we visited on 22 and 23 October, the provider was completing a ligature review of the PICU and had reviewed the majority of ligature risk assessments on the ward, apart from bedrooms not currently in use. The most up-to-date versions were easily available for staff in the nursing office. Staff we spoke with told us they knew where ligature risks were and how to manage them. Managers had started to take photographs of some of the ligature points, so staff were clear about the risk and how to mitigate it. Staff had removed the concrete bin in the courtyard which had made a ligature risk accessible. Some ligature risks identified on the provider's action plan still remained, for example, two disused nurse alarm call boxes which could not be removed. The provider was aware of these and had plans to resolve this and were managing the risk in the interim with staff observations.
- However, the hospital struggled to accurately present a detailed description of the risk in the Priory's mandatory ligature risk audit document, which did not allow staff to insert additional free text. This meant staff could not specify the nature of the risk effectively and had to insert this information elsewhere in the form.

Safe staffing

- Managers reviewed staffing levels across the hospital after the inspection in June 2019. In the forensic service, staffing on Ermine ward had increased from six to eight nursing staff plus additional staff for constant observations. Orwell ward staffing increased from five to six staff plus additional staff for any constant observations. These staffing levels were higher than was prescribed in the Priory's staffing ladder.
- Staff had stopped using blanket restrictions or institutional practices to manage the wards which were over two floors. Patients could access all parts of the ward throughout the day. On Ermine ward, staff encouraged patients to remain upstairs between 15:00 and 16:45 so staff could have 'protected time' to complete paperwork. However, patients wishing to remain downstairs were able to do so. We reviewed rotas for both wards for a three-week period in September and October 2019 and confirmed the provider had maintained these staffing levels consistently.
- We reviewed observation sheets for Ermine ward and Orwell ward for the same period. On Orwell ward, there was one occasion where managers did not allocate anyone for level two observations and five occasions when staff did more than two hours of intermittent or constant observations without a break, contrary to the provider's policy and best practice. On Ermine ward, there were 20 occasions where staff did more than two hours of observations without a break.
- While patients had access to both upstairs and downstairs areas of the wards, two staff told us that there were occasions when there was only one member of staff on duty upstairs. We were unable to verify this.
- The provider helped patients access section 17 leave on the forensic/secure wards. Staff we spoke with told us that staffing increases helped them ensure staff could access escorted leave as planned. Staff confirmed that the number of times they had to cancel or re-arrange this had reduced significantly.
- There were enough staff deployed on the PICU to ensure the safety of the patients present on the ward. On 3 October and on 22 and 23 October, there were four staff

for three patients, with an additional 'floater' who was based on the ward and deployed on other wards when needed. However, managers told us that the Priory staffing ladders indicated that when the number of patients rose to eight, the number of staff would only rise to five, plus any requiring constant observations. Staff were concerned that this might not be sufficient to keep patients safe, given the challenges presented by the patient group.

- Staff on the PICU were up to date with mandatory training and had received additional training in relation to risk assessments and relational security, specifically tailored to the PICU. Some staff had missed this training, but the provider had planned how to ensure these staff and newly recruited staff could receive that training.

Assessing and managing risk to patients and staff

- Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed them regularly. We reviewed 17 patient records. All contained up-to-date, detailed risk assessments which evidenced regular reviews with the patient. On the PICU, staff completed risk assessments and risk formulations for patients, which included detailed descriptions of both current and historical risks and updated these appropriately after incidents. Risk assessments linked into the 'keeping safe care plan'. This care plan contained an up-date-review of patient risk and a risk management plan for staff to follow.
- However, on the PICU, the initial risk assessment in one record lacked detail and staff did not complete a detailed risk formulation and assessment until 12 days later. In another record, staff had not updated a risk assessment after one incident. On Ermine and Orwell wards, there was no evidence in patient records that staff had reviewed all patients' risk assessments, nursing assessments, associated care plans and positive behaviour support plans on a weekly basis as detailed in the CQC's conditions. The multidisciplinary team reviewed all patients monthly on secure/forensic wards, including risk assessments and care plans.
- At the inspection in June 2019, there were insufficient staff on Orwell ward to conduct patient searches consistently after leave. Staff we spoke with on Orwell ward told us that due to the increase in staffing levels, staff searched all patients on unescorted leave when they returned to the ward. Staff did not routinely search patients on escorted leave, but some random searches did take place. On Ermine ward, staff searched all patients on their return from unescorted leave.
- The provider had assessed that all patients in the service were appropriately placed on the wards as required by CQC conditions after the inspection in June 2019. Staff had reviewed its admission criteria for the medium and low secure services and reassessed all patients to ensure they continued to meet the criteria for admission.

Safeguarding

- The numbers of safeguarding referrals from the PICU had dropped significantly since the inspection in June 2019 due to the reduction in patient numbers on the ward. Staff were aware of safeguarding procedures and made referrals appropriately.

Reporting incidents and learning from when things go wrong

- Incidents on PICU had reduced as patient numbers had fallen. There were 81 incidents between 1 August and 21 October. There were several incidents of verbal and physical interaction between patients, but these were easily and appropriately managed by staff.
- Staff did not always categorise the severity of incidents appropriately on the PICU. For example, we found 14 examples of self-harming behaviour, including head banging and tying a ligature, assaults against staff, which reporting staff had classified as 'no harm/impact'. We were concerned that staff might minimise the importance of some behaviours and that this could have a negative impact on patients.

Are forensic inpatient or secure wards well-led?

This inspection was a focused inspection across two core services. The report reflects what we found in the three wards we inspected. These were:

- Ermine ward, a 19-bed medium secure service for men with a mental illness
- Orwell ward, an 18-bed low secure service for men with a mental illness
- Wimpole ward, a 12-bed psychiatric intensive care unit for women with a mental illness

Forensic inpatient or secure wards

Culture

- Staff we spoke with were positive about the work they were doing with patients and proud to work on the wards.
- Staff on the PICU felt that there was a high level of teamwork on the ward and that staff worked well together and supported each other well.
- Staff felt valued and respected by their managers. The ward manager on the PICU had received additional support and opportunities to develop skills and knowledge around working on the unit.
- Managers on the PICU had set up systems for patients to indicate that they needed additional support, for example sitting on particular chairs on the ward within sight of the nursing office. We saw staff attending to patients who had requested additional time.
- Staff told us that the atmosphere on the PICU had improved and were positive about the improvements. Staff on the forensic/secure wards felt that the additional staffing had improved the safety of the ward and allowed them to engage more positively with patients.

Management of risk, issues and performance

- Managers had ensured that the PICU was clean and well maintained and that they had completed most of the work identified in their action plan. The ward was clean, and systems were in place to ensure that housekeeping staff cleaned the ward regularly and monitored it throughout the day. However, learning across services had not taken place. Environmental concerns identified in the PICU had not transferred to other parts of the hospital, including the forensic/secure wards. We found significant concerns in Ermine and Orwell wards, including dirty toilets, a dirty kitchen area, strong odours and damage to the building that had not been addressed.
- The service had not ensured they had met all the conditions imposed by the CQC. The provider's action plan in response to CQC conditions had stated that staff would review risk assessments, care plans, nursing assessments, associated care plans and positive behaviour support plans on a weekly basis. While the multidisciplinary team ensured that staff reviewed all patients monthly, managers did not ensure that staff reviewed all patient risk assessments, nursing assessments, associated care plans and positive behaviour support plans on a weekly basis as detailed in CQC conditions and their action plan.
- The provider had ensured that managers and clinicians assessed the suitability of patients for admission to the PICU appropriately as required by CQC conditions and their own action plan. Managers had assessed that patients within forensic services were suitability placed on the wards as required by CQC conditions and their own action plan. Managers had reviewed the wards admission criteria and reassessed all patients across the hospital to ensure that patients continued to meet the criteria for admission.
- At the inspection in June 2019, managers had not ensured there were enough staff to maintain the safety of patients and facilitate patient leave and therapeutic activity consistently on Ermine and Orwell wards. Managers used the Priory's staffing ladder to determine how many staff to allocate to each ward and had not structured staffing levels to ensure that there were enough staff met the patients' needs. The staffing ladder did not adequately consider the number of staff needed to manage patients on wards that had two floors. The provider had increased staffing levels to ensure that there were sufficient staff on all wards to carry out safe care and treatment of patients. At this inspection, managers had ensured they deployed additional staffing to Orwell and Ermine wards to allow patients access to all parts of the ward and to allow patients to access section 17 leave as planned. However, some staff on Ermine and Orwell wards completed constant observations for more than two hours without a break and managers did not maintain sufficient oversight of this.
- Priory staffing ladders indicated that staffing ratios would reduce on the PICU as the provider admitted more patients and senior managers had not given any clear direction about how staff would manage this. Some staff were concerned that there would not be sufficient staff to keep patients safe when the ward was full. Managers told us that the staffing ladders were under review.
- Staff showed us that the Priory's environmental risk assessment tool was an obstacle to creating accurate and detailed ligature risk assessments. Senior managers had not resolved this issue. However, managers had

ensured that printed copies of ligature audits were the most up-to-date versions available and that managers disposed of older versions and made them easily available to staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure an appropriate standard of cleanliness and infection control across all wards.
- The provider must ensure there are systems in place to assess, monitor and improve the service and environment and ensure that concerns are addressed quickly and effectively.
- The provider must ensure that staff undertaking constant and intermittent observations, do so for no more than two hours without a break, in line with their own policy and best practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured appropriate standards of cleanliness and infection control on the forensic wards. This was a breach of Regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured there were systems in place to assess, monitor and improve the quality of the service. The provider had not ensured that all wards were clean and that staff addressed environmental concerns quickly and effectively. This was a breach of Regulation 17

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that all staff undertaking constant and intermittent observations, did so for no more than two hours without a break, in line with their own policy and best practice. This was a breach of Regulation 18