Penhayes

Quality Report

Penhayes Kenton
Exeter, EX6 8JB
Tel: 01626 899159
Website:www.moduscare.com

Date of inspection visit: 14, 16, 19 October 2015
Date of publication: 22/01/2016

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

Summary of findings

Contents

Penhayes

Services we looked at -
Wards for people with learning disabilities or autism and complex mental health needs

Summary of this inspection

Background to Penhayes

Penhayes was registered as an independent mental health hospital for adults who may have an autistic spectrum disorder and/or mental health needs, some of whom required treatment or assessment under the Mental Health Act 1983. Within the last year the service discontinued its function as a hospital and no longer provides a service to people detained under the Mental Health Act 1983.

Penhayes is currently functioning as a residential service specialising in providing support for adults with autism and/or learning disabilities and complex needs. Some of the complex needs may include mental health needs. The service has capacity to accommodate up to five patients; three patients within the main building and two patients in the annex. The service was full at the time of our inspection with three males and two females.

Penhayes is registered with the Care Quality Commission for the following regulated activities: accommodation for persons who require nursing or personal care; assessment of medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder and injury. However, the provider is only delivering a service against one of these regulated activities – accommodation for persons who require nursing or personal care.

The manager is in the process of applying to become the registered manager for Penhayes.

Four patients were funded by the Devon Clinical Commissioning Group (CCG) and one was funded by Gloucester CCG.

Three patients were subject to a Deprivation of Liberty Safeguards (DoLS) and two had DoLS applications in process.

Our inspection team

The team that inspected the service comprised of three CQC inspectors and an inspection manager.

Why we carried out this inspection

We reviewed two areas in response to concerns raised around safety and effectiveness of the organisation.

During our inspection we looked at whether services were safe and effective.

This was the first inspection of Penhayes since they stopped functioning as a hospital.

At the last inspection on 23 June 2013, while the service was still a hospital, Penhayes was meeting the essential standards under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We did not rate the service on this inspection.

How we carried out this inspection

We reviewed two areas in response to concerns raised. We looked at the following areas:

- Is it safe?
- Is it effective?

This was an unannounced visit.

Before the unannounced inspection, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

Summary of this inspection

- looked at the quality of the environment and observed how staff were caring for patients;
- observed interactions between staff and patients who were using the service;
- spoke with three relatives of patients;
- spoke with the deputy manager, manager and managing director;
- spoke with five other staff members; including a psychologist and four support workers;
- received feedback about the service from care co-ordinators and commissioners;
- reviewed minutes from multidisciplinary meetings;
- looked at five care and treatment records including risk assessments;
- looked at a range of policies, procedures and other documents relating to the running of the service; and
- looked documentation relating to the Mental Capacity Act (MCA) 2005 and Deprivation of liberty Safeguards (DoLS).

What people who use the service say

We were unable to speak with patients at the time of our visit because two of the service users were out and another person declined to speak with us. We met one service user who showed us around her flat. Staff interaction with this person was positive, kind and caring. We observed that staff were attentive to patients and that despite high levels of observations, the environment was predominantly calm and relaxed. We observed positive and respectful interactions and discussions between staff and patients.

An external healthcare professional told us that they were impressed with the attitude, respectful manner and professionalism of the staff towards patients at Penhayes. They told us that the staff always appeared dedicated and compassionate. Patients were supported to attend local community activities and amenities.

It was clear from our review of records that staff had daily discussions with patients about their care. There was evidence of patient comments within care records and meeting minutes which showed that choice and preference regarding daily aspects of their care, had been offered and acted upon. Independent mental capacity advocates had assisted patients in understanding their care and ensured the patient voice had been heard. For example, patient's opinions regarding mental capacity act decisions were clearly considered and recorded.

We spoke with five relatives of patients. Four relatives gave us positive feedback about Penhayes. One relative told us that the staff always work hard to meet the needs of their family member. They told us that the staff are lovely and they have no concerns about the safety or wellbeing of their family member. One relative told us that the staff are always kind and caring and this (Penhayes) had been the best place for their family member. They thought the staff were dedicated and wonderful. Another relative told us that their family member always seems relaxed and has their own space to move around. They said "we have no complaints". One relative told us they could not have wanted better for (their family member) and the staff always involved them and worked around them. Another relative told us that they did not feel well informed or involved by Penhayes. They told us that they were in the process of making a complaint to the service.

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?

- Most of the environment was clean with the exception of one bedroom and toilet.
- There was evidence of positive risk taking. Staff took well thought out and proportionate risks to improve the experience of patients.
- The layout allowed staff to observe in all the communal areas. Blind spots were mitigated by high levels of staffing and observation levels.
- Safe staffing levels were in place and were adjusted to accommodate any change in level of need or risk.
- All staff were trained in positive behaviour management.
- Staff knew how to report incidents and there was regular feedback.
- Staff were knowledgeable of the safeguarding process and knew what types of incident would constitute a safeguarding alert.
- Staff managed medicines safely and in line with policy and legislation. There was medicines management oversight from doctors who attended multidisciplinary meetings and conducted regular medical reviews.

However, incident records on the use of restraint and or seclusion practices were not clear. For example, the majority of incidents, recorded as seclusion and restraint, were not actually seclusion or restraint. This confused the overall figures when analysed because there appeared to be more incidents than there had been.

One bedroom and toilet had not been cleaned recently as there was a build-up of dirt around the floor and bottom of the walls and the toilet was impacted with faeces that had dried. We raised this with the manager and immediate action was taken by staff to rectify this. A drawer face, in the same room, was missing and metal runners were exposed. This posed a risk to patient and staff safety.

Are services effective?

- Patients had received detailed multi agency assessments prior to admission. This included assessments of patients' physical health needs.
- Patients had access to a range of psychological therapies. These were provided by external professionals or organisations.

Summary of this inspection

- Each patient had up to date person-centred care plans. Care plans were available in easy read formats if patients needed them.
- Training was available for staff to undertake their specialist roles alongside mandatory training.
- There was effective working relationships with key staff and services, such as GPs, the local authority and other health and social care organisations.
- Information was available to patients about how to access the Independent Mental Capacity Advocacy service (IMCA).
- Mental Capacity Act (MCA) assessments were in place and adhered to the principles of the MCA. Deprivation of Liberty Safeguard authorisations were complete and comprehensive. Staff had a reasonable knowledgeable about the use of the MCA and DoLS.

However, most staff had not received supervision and appraisal. Some staff had received supervision but not at the frequency outlined in the providers supervision policy. This was confirmed by records and what the manager told us.

The number of staff that had completed training varied from course to course. Overall, around 50 percent of staff had completed autism and aspergers training, mental capacity act, first aid, infection control, mental health, diet and nutrition, learning disability awareness and communication training. There were no future training dates booked for mental capacity act, first aid, infection control, mental health, diet and nutrition or learning disability awareness.

Records did not always make it clear that alternative methods should be attempted, where possible, before PRN (as and when required) medication is given.

One MCA assessment dated back to 2013 and was still in the patient's record. Staff could not confirm if it was still being used as a current and valid assessment.

Detailed findings from this inspection

Wards for people with learning disabilities or autism

Safe	
Effective	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- Most areas of the service were clean. The environment had been maintained and furniture and fixtures were in reasonable condition. There was a whole service cleaning schedule that oversaw cleaning of all areas at Penhayes, however, it contained limited detail and it was difficult to monitor if cleaning of all areas had been completed. The manager showed us a (daily tasks sheet) which listed daily tasks for the cleaning of two patients flats and the communal areas. These contained limited detail and required staff to tick to confirm completion.
- One bedroom and toilet had a build-up of dirt around the floor and bottom of the walls, and the toilet was impacted with faeces that had dried. We raised this with the manager and immediate action was taken by staff to rectify this. The manager showed us a cleaning schedule that the patient used to maintain their living area. This schedule indicated the different areas to be cleaned throughout the week and specified the cleaning material to be used. However, there wasn't a clear log of dates for when cleaning had actually taken place, and from what we observed, it was clear that cleaning had not taken place recently in this bedroom and toilet. A drawer face, in the same room, was missing and metal runners were exposed. This posed a risk to patient and staff safety.
- Hand wash signs and hand cleaning products were positioned throughout the buildings. Staff had knowledge of infection control procedures.
- Equipment was clean and maintained. Portable appliance testing stickers were in date.
- The layout allowed staff to observe in all the communal areas. Blind spots were mitigated by high levels of staffing and observation levels.
- There were anti ligature fixtures in patient areas including bedrooms, and bathrooms.
- Staff were present within the vicinity of patients at all times. The general communal area also allowed patients to be observed. However, these areas were not always used by patients as they chose to spend time in their own living areas or spend time going out into the community. While in their living areas patients were supported and observed by staff who had been allocated to them. Observation levels were discussed and agreed in multidisciplinary meetings, recorded in care plans and where required agreed as part of one of the deciding aspects of a patients Deprivation of Liberty Safeguards authorisation.

Safe staffing

- There were 29 permanent members of staff and three new staff due to start at Penhayes. Recruitment was underway for another five positions.
- Safe staffing levels were in place and were adjusted to accommodate any change in need or risk. One patient, with complex needs, had four staff supporting them during the day and two at night.
- There were eight staff working per shift. Additionally there was one member of staff working eight in the morning to five in the evening and one staff member working nine in the morning to seven in the evening. There were four or five staff on a waking night shift plus one sleeping night shift. The number of staff on shift varied depending on the level of risk and need of the patients. In general there were two senior members of staff on per shift plus six care support workers.
- The manager was able to adjust the staffing and the duty roster to accommodate the needs of the client group. For example, the unit was currently working with a twilight shift as more staff were needed at this time of day to meet the needs of the patient group.
- Agency staff were used most nights. The manager told us that they try not to use more than two agency staff per shift, but there had been occasions when they have had to. They told us that, where ever possible, they only used agency and bank staff that were familiar with the Penhayes and had undertaken necessary training to safely work with the patients.
- Penhayes did not provide agency staff with training. The agency staff had received training from the agencies they were sourced from, and the manager sought

confirmation of this through relevant records. For example, the agency had sent staff profiles which listed the training staff received. The manager told us that agency staff were never allowed to dispense medication and they were not allocated to patients with the most complex needs.

- All patients had a named care worker and were allocated one to one time to discuss their care and wellbeing. We observed patients receiving one to one time and records reflected that this time was regularly given.
- The manager told us that some permanent staff had worked at Penhayes for years, really liked working there and were dedicated to the service. Records and staff confirmed this. The manager also told us that a number of staff had left or transferred to other units due to the intensity of some of the work and aggression from some of the patients. There were 10 leavers between 01 May 2015 up to the date of this inspection, two of them left after a couple of days as they did not feel this was a job for them and one person left within 2 weeks of starting their employment due to personal circumstances. One of the leavers was a staff member in hospital and on long term sickness and did not return. Others transferred to different services provided by the same organisation.

Assessing and managing risk to patients and staff

- There was a seclusion room which was known as the "supervised withdrawal area". This was for the exclusive use of one patient. There were care plans, management plans and a unique policy and protocol for its use. This had been drawn up in conjunction with the provider, multidisciplinary team and Clinical Commissioning Group.
- Incident records on the use of restraint and or seclusion practices were not clear. For example, the majority of incidents, recorded as seclusion and restraint, were not actually seclusion or restraint. This confused the overall figures when analysed because there appeared to be more incidents than there had been. There were 33 recorded incidents of seclusion in September 2015. Of these 33 incidents, 20 within the "supervised withdrawal area" were occasions when the patient had taken themselves to the room. There were 12 occasions where the patient had become aggressive towards staff and staff vacated the patients living area, locking the door behind them. On one occasion restraint had been used to escort the patient to the "supervised withdrawal area". The patient was observed at all times, records were kept of each incident and most incidents only lasted between five to 10 minutes.
- All staff had received three day positive behaviour management training. This training included sessions on the use of restraints and safe holds. Positive behaviour training is a british institute of learning disabilities (BILD) accredited course that encourages the use of a positive behavioural support model. The aim of the training is to enable staff to deliver person-centred approaches to the prevention and safe management of difficult behaviours. The manager had completed the trainer's course and was re-accredited as a trainer annually. This was also a british institute of learning disabilities (BILD) accredited course.
- The manager told us that most staff were trained in safeguarding adults and all staff we spoke with knew how and when to make a safeguarding alert. The training matrix showed that all staff with the exception of one had received safeguarding training.
- We reviewed the records of all five patients at the service. Each patient had detailed risk assessments and risk management plans. These were updated in the fortnightly multidisciplinary meetings. However, it was not evident that risk was always thoroughly and fully considered and discussed at multidisciplinary meetings. For example, where there had been significant incidents of aggression; action points regarding management of physically aggressive behaviour, analysis of behaviour and consideration of risk management plans had not always been documented within the meeting minutes. Risk was considered as part of daily handover meetings.
- There were frequent incidents of physical and verbal aggression towards staff. Between August 2014 and September 2015 there had been 51 recorded incidents of physical aggression towards others, resulting in 13 minor injuries and four moderate injuries. One member of staff was on long term sick leave due to three aggressive incidents.

Medicines Management

- Medicines were stored securely and maintained accurately. Records were made of medicine refrigerator and room temperatures on a daily basis and these were all within the expected temperature ranges.

- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations.Orders were fulfilled by a local pharmacy in Exeter who collect repeat prescriptions from the GP practice.
- Medication was checked on a weekly basis. The staff completed a medication audit on a monthly basis. The audit was checked by the manager for any discrepancies or issues. If any action was required the manager followed the providers reporting procedures. The medication checks and audits were completed by the manager, deputy manager or team coordinator and always witnessed by another member of staff.
- All the medication was stored in a locked medication cabinet in a room within the staff office. All medicines were logged on medication administration records and dispensed by two staff members in accordance with the medication policy.
- The allergy status for all patients was clearly recorded.
- One patient was prescribed an anti-psychotic medicine and it was not evident from records that their physical health checks were being completed. Staff told us that this was currently under review. They informed us that the consultant psychiatrist and a mental health nurse from the local NHS community team were monitoring this patient closely. Records confirmed there had been input from both the doctor and mental health nurse. However, the staff at Penhayes were unclear as to why the person had been prescribed the medicine or that physical health checks should have been carried out. One member of staff told us that it was a medication they were taking prior to being admitted to Penhayes.
- Excluding the new starters, 21 out of 25 established staff had received medicines management training and three were scheduled for updates. Two staff had not received the training and were not yet booked for an update. The manager told us that staff only handle medication if they have received the training. The staff told us that the consultant psychiatrist was always available for advice. Staff told us about the british national formulary (BNF) pharmaceutical reference book, which they had access to for detailed and accurate information regarding medication.
- All medicine incidents were reported via the organisation reporting system. From our review of the incident reports we found that a number of minor incidents had occurred. These were mainly recording incidents and included staff putting in the wrong time or not signing when medication had been given. Corrections and notes were clearly recorded on the medication administration records.
- The organisation had an up to date policy on the administration of covert medication. No patients were subject to covert medications.

Track record on safety

- We reviewed recent incidents. There were 18 incidents that required support from the emergency services or required reporting to other professional bodies. Some of these incidents resulted in moderate or serious injury to service users, staff or members of the public. Records showed that the staff had taken expected and required actions at the time of the incidents. For example, the patient was supported in the least restrictive way while de-escalating a volatile situation. There was evidence of post incident support for the patient.
- Incidents were discussed and reviewed within multidisciplinary care programme approach (CPA) meetings and staff debriefs. The frequency and pattern of incidents was analysed for each patient and reviewed every six months. Penhayes had a two tier debrief system. Tier one was a house debrief, which could be facilitated at any time required. Tier two was a formal debrief which occurred following serious incidents. These meetings were facilitated by the manager or service manager and Penhayes staff would attend.
- One serious incident had occurred in the community. The serious incident had not been formally reviewed at the time of the inspection. However, staff had postponed further outings of a similar nature until a review had taken place and the best way forwards had been determined. CPA meeting minutes showed some mention of the incident and discussion around possible future plans. However, the incident was not actually formally reviewed. It was not clear from the CPA meeting minutes what the details of the incident were, why the incident occurred, what immediate actions were taken, how risks had been reassessed and what immediate and future plans were going to be put in place as a result of the specific incident.
- All staff we spoke with understood the process of incident reporting and knew what incidents needed to be reported and how to report them.
- The frequency of incidents at Penhayes was high, including the aggression experienced by staff from the

patients. This was fully acknowledged and accepted by the manager and the team, as a consequence of the complexity and severity of some patient's mental health conditions and challenging behaviours. As a result there was significant input from other organisations and professionals including the local NHS community mental health team, Clinical Commissioning Groups and social workers. Risks were increased due to a high number of new admissions and a high number of new staff commencing work at Penhayes.

- It was evident that the team worked effectively with external professionals to reduce and where possible prevent risks to patients and staff. This was evident from MDT minutes and from what external professionals told us.

Reporting incidents and learning from when things go wrong

- When we spoke to staff, they were able to show us that they knew how to report incidents.
- Feedback from the investigation of incidents was shared amongst the team via team meetings or debriefs. However, the detail and analysis of those incidents was not always clearly recorded within meeting minutes, and where they were available, they were not always easily accessible.
- Changes made following an incident were seen during our inspection in current risk assessments and care plans. For example, observation levels were changed to reduce the likelihood of one incident being repeated. The changes were reviewed regularly and there had not been a repeat of the incident. This was done in a way that was recognised as being least restrictive for the patient.
- The service operated in an open and transparent way where incidents were reported and investigated appropriately. Learning from these incidents was completed through team debriefing and team meetings.
- Learning and outcomes were evident from the meeting minutes and from what staff told us. All reportable serious incidents were submitted for statutory monitoring.
- Staff confirmed that they received feedback on incidents and were confident that the service was transparent and explained to patients if things went wrong.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Patients had received detailed multi agency assessments prior to admission. This included assessments of patients' mental and physical health needs. Assessments were reviewed and updated throughout a patients stay at Penhayes. There was regular input from medical staff and qualified nurses from the local NHS trust community teams.
- Staff told us that there was regular physical health monitoring for patients via the local GP. Care programme approach reports documented detailed physical health care information about patients. Records identified patients physical health needs and the measures required to address these needs. For example, patients had been supported in receiving treatment from the dentist and opticians, skin care treatment from their GP and support with dietary requirements.
- On-going physical health checks such a blood pressure or weight monitoring took place as needed. This was discussed and reviewed at multidisciplinary meetings and in CPA meetings. However, records for one patient from 2013 had indicated a need to monitor blood pressure daily due having high blood pressure and refusing to take medication. These checks had stopped but it was not clear from the care records what the rationale for stopping was or if the checks should have been stopped at all. The patient was now on regular medication and staff told us that they were stable.
- Care plans and risk assessments were all in paper format and were accessible by staff working in the service. All five records we looked at confirmed that care plans were regularly reviewed and updated. Care plans detailed clear instructions, advice and guidance to care staff about how best to meet patient's needs. However, records did not always make it clear that alternative methods should be attempted, where possible, before PRN (as and when required) medication is given. The manager and staff were able to explain the alternative measures that they would take and there was a system in place for staff to record why PRN medication was required, and whether alternative interventions had

been attempted. However, this had not always been recorded. Some staff had recorded that they had not attempted alternative interventions and they had not given a rationale. Some staff had recorded brief sentences or single words including 'verbal de-escalation', 'verbal reassurance', 'self-calming' and 'distraction'. It was not possible to tell how these alternative methods were implemented and why they were not successful. Some patients had 'none' recorded under alternatives to medication and 'no' under the question of whether there were any other measures that could be used.

- Patients had access to their care plans and they could be made available in easy read format as required. Patients had been involved in their assessment of need and planning of care. For example, care plans contained comments made by the patients regarding their preferences to different aspects of their care.
- During our inspection, we talked with staff and reviewed records relating to handover meetings. Each patient using the service was discussed in detail including levels of current risks, observation levels, sleeping patterns and medication changes. Following handover, patients were engaged in daily discussions about what they would like to do in the morning or afternoon.

Best practice in treatment and care

- Patients had access to a range of psychological therapies. These were provided by external professionals or organisations. For example, an external psychologist had been used to provide dialectical behaviour therapy and positive psychology interventions and attended the service one day per week.
- There was evidence, from observation and our review of records, that the National Institute for Health and Care Excellence (NICE) guidelines around positive behaviour support was embedded in practice.

Skilled staff to deliver care

- Since the service stopped functioning as a hospital it no longer has registered mental health nurses as part of the staff team. However, there were consultant psychiatrists in place who oversaw the care of patients at Penhayes. There was also input from external agencies in the form of a psychologist and mental health nurses from specialist NHS community mental health teams.
- Some of the permanent care support workers received training to undertake their specialist roles and were supported to complete mandatory and developmental training. Some of the specialist training included: autism and aspergers awareness, communication, diet and nutrition, epilepsy awareness, learning disability awareness, personality disorder awareness, person centred approaches and positive behaviour management.
- Most staff had current training for care of medicines, equality and diversity, fire safety, food hygiene, health and safety, manual handling and positive behaviour management. However, the number of staff that had completed training varied from course to course. Overall, around 50 percent of staff had completed autism and Asperger's training, mental capacity act, first aid, infection control, mental health, diet and nutrition, learning disability awareness and communication training. In addition to the new starters, nine established staff were booked for 34 training sessions across eleven courses. There were no future training dates booked for mental capacity act, first aid, infection control, mental health, diet and nutrition or learning disability awareness. The manager told us that the training schedule is formulated on a quarterly basis. An increased number of admissions in a short space of time and a large influx of staff had impacted on staff training.
- A training induction programme was in place for new starters. This included being additional to the established staff numbers and shadowing more experienced colleagues on shift, whilst learning their role. These documents were monitored by senior staff and measured outcomes, personal development and competencies.
- There was effective working relationships with key staff and services, such as GPs, the local authority and other health and social care organisations.
- According to the provider's policy on appraisal and supervision, staff should receive regular supervision every 12 weeks with the fourth session being an appraisal. However, most staff had not received supervision and appraisals. This was confirmed by records and from what the manager told us. From our review of staff records, four out of 25 staff, excluding new starters, had received supervision and only one had received an annual appraisal. The manager told us that new staff on probation receive review meetings which work in conjunction with the supervision policy and

count as supervision. There were 18 staff on probation and 12 out of 18 had not received their first meeting within the one month time frame specified in the provider's policy.

- The manager told us that with four admissions in a short space of time and a large influx of staff, the supervisions and probationary reviews had not been kept to appropriate and expected time frames. This meant that multiple factors presented a high risk to patients and staff at this service. For example, an influx of new admissions and high levels of new staff are high risk factors. Some of the mechanisms that would reduce and prevent risks, including support, supervision and training were not being met.

Multidisciplinary and inter-agency team work

- We reviewed multidisciplinary meeting minutes. The quality of the minutes varied. Some contained comprehensive notes of the discussion held and clearly listed what the outcomes were, and who was responsible for completing them. Others lacked detail or were incomplete. For example, in one case, new incidents of aggression were discussed but there were no action points regarding the management of physically aggressive behaviour. There was no evidence of analysis of behaviour and no evidence of consideration of change to risk assessments and risk management plans. However, after discussion with the manager, we found this information was present within a detailed care programme approach meeting held in October 2015.
- The multidisciplinary meetings could, and on regular occasions did involve a psychiatrist, external psychologist, external nurse, social workers, safeguarding leads and representatives from the clinical commissioning groups. An advocate was also available and present to support patients.
- There was effective and collaborative working relationships with teams outside of the organisation, including with the local authority, NHS community mental health team and regular liaison with the GP. Penhayes received input from the local learning disabilities team, the intensive assessment and treatment team and the primary care liaison nurse.

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

- Penhayes no longer functions as an independent hospital and so no longer admits patients detained under section of the Mental Health Act 1983.
- One patient was on a community treatment order. A community treatment order is a legal order made by the mental health review tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community. There were detailed assessments and care plans in place to support the patient in relation to the conditions outlined by the community treatment order. This was overseen by the consultant psychiatrist and regularly reviewed.

Good practice in applying the Mental Capacity Act

- Information was available to patients about how to access the Independent Mental Capacity Advocacy service (IMCA). One patient had received regular support from the IMCA.
- Mental Capacity Act (MCA) assessments were in place and adhered to the principles of the MCA. However, one assessment was still in a patient's record and dated back to 2013. Staff could not confirm if it was still being used as a current and valid assessment. MCA assessments should be decision specific and time limited. If an assessment is no longer valid then it should be made clear and if it is still valid then a new one should be completed, in line with the requirements set out under the Mental Capacity Act 2005.
- Three patients were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation and two patients had DoLS applications submitted.We reviewed the paperwork and found all necessary forms were present, and completed appropriately. Staff had demonstrated knowledge about the use of the MCA and DoLS.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff receive training and training updates.
- The provider must ensure that staff receive support through regular supervision and annual appraisal.
- The provider must ensure that patient records are clear, complete and easily accessible. This includes records around use of alternative measures before PRN medication is given; rationale for discontinuing blood pressure monitoring and making a clear distinction in the recording of incidents identified as restraint and seclusion.
- The provider must ensure that MCA assessments are clearly identified when they are no longer valid or ensure new assessments are conducted in line with the requirements set out under the Mental Capacity Act 2005.

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
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15: Premises and equipment This breach relates to the poor state of one patient bedroom and toilet at Penhayes. The bedroom and toilet were dirty. A drawer face was missing and the metal runners were exposed. 15. —(1) All premises and equipment used by the service provider must be— (a) clean and (e) properly maintained. This was a breach of Regulation 15(1)(a)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance The breach relates to the unclear recording of incidents regarded as seclusion and restraint and the lack of a rationale for discontinuing the monitoring of a patients' blood pressure. It relates to some records which were unclear regarding action points on the management of physically aggressive behaviour, analysis of behaviour and consideration of change to risk assessments and risk management plans. It relates to the lack of clarity around the use of an old mental capacity assessment which was still in a patients care records.

This section is primarily information for the provider

Requirement notices

17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This was a breach of Regulation 17(1)(2)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18: Staffing This breach relates to the lack of staff supervision, appraisal and training. Persons employed by the service provider in the provision of a regulated activity must receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014