Maryfield Court

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Good
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker

Chief Inspector of Hospitals

Overall summary

Our rating of this service went down. We rated it as inadequate because we rated two key questions as inadequate (safe and well-led), two as requires improvement (effective and caring) and one key question (responsive) as good. This was because:

- The service did not provide safe care.
- The ward environments were not fully safe, secure and clean. We issued a warning notice to the provider to make sure they improved maintenance and cleanliness of the premises.
- Staff did not always review or manage risk well. Staff did not always update patients' risk assessments following incidents.
- Managers did not fully identify all ligature risks and did not fully review restraint incidents to ensure they accurately recorded and minimised the use of restrictive practices.
- Staff did not develop individualised holistic, recovery-oriented care plans.
- Staff did not fully record how they actively involved patients and families and carers in care planning and decisions.
- The service was not well led and the governance processes did not ensure that ward procedures ran smoothly. There was too much responsibility placed on one senior manager to manage strategically and operationally this hospital and another of the provider's hospitals.
- We identified shortfalls not picked up by the provider's own audits. The provider had not addressed the shortfalls we found on the last inspection. We issued a warning notice to the provider to make sure they improved the governance arrangements.

However:

- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The wards had enough nurses and doctors. The ward teams included or had access to a range of specialists required to meet the needs of patients on the wards.
- Managers ensured that staff received supervision and appraisal. The ward staff worked together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients.
- The service managed referrals well so that patients were admitted quickly and patients were discharged promptly once their condition warranted this.

Summary of findings

Contents

Inadequate

Maryfield Court

Services we looked at

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

Summary of this inspection

Background to Maryfield Court

Maryfield Court is an independent hospital owned and operated by ASC Healthcare Limited. It is located in the Whalley Range area of Manchester. It provides acute mental health inpatient care for up to 27 patients. The service is divided into four distinct apartments - each apartment accommodates between six to eight patients. At the time of the inspection, apartments one and two were open providing accommodation for up to 13 patients.

- Apartment one had 7 beds for women.
- Apartment two had 6 beds for men.

Maryfield Court is registered for the regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury.

All the patients at Maryfield Court are placed there on a spot purchase agreement by NHS trust bed managers when they cannot secure a local acute mental health bed. Patients are admitted for short-term assessment and/or treatment before they are transferred to a hospital bed in the patient's local NHS Trust or discharged home with community based mental health support. At the time of this inspection, two patients were receiving assessment and treatment at Maryfield Court.

There is a registered manager in place, currently they are acting as the registered manager for another hospital as well.

Maryfield Court opened in August 2018. It has been inspected once before in February 2019. At that inspection we rated the service as requires improvement overall and for the effective and well-led key questions; the other key questions (safe, responsive, and caring) were rated as good. At that inspection we identified two regulatory breaches:

- Regulation 12 - safe care and treatment due the lack of physical health checks when patients were admitted; and
- Regulation 17 - good governance due to records shortfalls as agency staff did not identify themselves as the author when they put entries on to the electronic care recording system.

The provider sent an action plan and stated they would make improvements by August 2019. On this inspection, we found these matters had still not fully been resolved and we found continuing issues. The hospital also shut for a short period in March 2019 and reopened on 25 May 2019 due to ongoing contract negotiations and a lack of referrals.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC inspector, and a CQC Mental Health Act reviewer. We were not able to include a specialist advisor or expert by experience in the inspection team because we inspected at very short notice.

Why we carried out this inspection

We inspected this service in response to concerns we had about the provider's compliance with the regulations, following an inspection of another location run by ASC Healthcare Ltd. This was an unannounced inspection, which means that staff did not know we were coming. We looked at all five key questions.

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and the provider.

During the inspection visit, the inspection team:

- looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with two patients who were using the service and one carer
- spoke with the registered manager and head of care
- spoke with six other staff members including the consultant psychiatrist, nurses, clinical psychologist, and health care assistants.
- attended and observed a multidisciplinary care team meeting
- looked at six care and treatment records of patients
- carried out a specific check of the medication management on two apartments, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

There were only two patients at the hospital when we inspected. We spoke with both patients. They were positive about their experiences at the hospital. Patients reported feeling safe and felt that the staff cared for them well.

Patients felt supported through their treatment and understood they were at Maryfield Court because there was no bed available for them in their home area. Both patients liked the hospital and felt that it was much better than other busy acute mental health admission wards they had been on in other hospitals.

Patients told us that the quality of the food was good and that staff were always available.

We spoke with one carer who told us that they were pleased with the care staff provided.

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?

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- Ward areas were not fully safe or clean. Many patient bedrooms were not well maintained and not fit for purpose. We issued a warning notice to the provider to make sure they improved maintenance and cleanliness of the premises.
- We identified ligature and other environmental risks that the provider had not identified themselves.
- Staff did not take proper measures to control the risk of exposure to legionella bacteria.
- The main door to the ward areas could not lock.
- There had been a number of patients going absent without leave directly from the ward and patients were able to scale the fencing and gate around the unit.
- Staff did not always review risks to patients well to anticipate and managing challenging behaviour.
- While the service mostly had good systems and processes to safely prescribe, administer, record and store medicines, it did not have an important stock of remedy medication when patients were given medication when they were agitated or displaying aggressive behaviour to help quickly calm them (also known as rapid tranquilisation).
- Staff did not always complete proper records following restraint incidents and managers did not review incidents robustly.
- We identified one incident where staff had not acted fully to protect a patient from the potential of abuse.
- Patients' clinical information was recorded in several places and it was not always easy for staff to maintain high quality clinical records. Due to shared access codes to the electronic records system, it was not always clear which staff member had entered patient notes.

However:

- Staff regularly reviewed the effects of medications on each patient's physical health.
- The service had enough nursing staff, who knew the patients and received basic training to keep patients safe from avoidable harm.

Summary of this inspection

Are services effective?

Requires improvement

Our rating of this service stayed the same. We rated it as requires improvement because:

- While staff assessed the physical and mental health of all patients on admission, the care plans they developed were not always individual to each patient. Care plans were not always personalised, holistic and recovery-oriented.
- While patients had basic physical health checks on admission, we found that full physical health screening including the taking of full histories on admission, was still not completed by staff despite this being raised on our last inspection.
- Staff participation in clinical audit, benchmarking and quality improvement initiatives was limited.

However:

- The ward team included or had access to a range of specialists required to meet the needs of patients on the ward, including a clinical psychologist and an occupational therapist.
- Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals and supervision. Managers provided an induction programme for new staff.
- Staff provided a range of care and treatment interventions with patients and consistent with national guidance on best practice. This included staff considering what was the most appropriate and targeted interventions they could provide given that patients only usually stayed at the hospital for a short time.
- Staff from different disciplines worked together as a team to benefit patients.
- The ward teams had effective working relationships with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005.

Are services caring?

Requires improvement

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

- Staff were not recording how they involved patients in developing their own care plans and risk assessments.

Summary of this inspection

- Patients were not routinely given copies of their care plans.

However:

- Both patients we spoke with were happy and felt they were treated with dignity and respect.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Patients were orientated to the ward on their admission.
- Patients had a say in the running of the hospital through feedback forms and 'you said, we did' initiatives.

Are services responsive?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff managed referrals well and worked with bed managers in the local NHS trusts. This meant that a bed was secured for patients when there was not an acute admission bed locally.
- Staff worked with NHS staff to ensure patients were transferred to their local hospital when there was a local bed available or discharged if patients were ready.
- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated complaints and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- While some bedrooms were not properly clean or well maintained, these areas were not in use and were locked off; the communal areas were mainly clean and well maintained.

Are services well-led?

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level.

Summary of this inspection

- Managers did not oversee performance well. Managers audits were limited in scope and did not address quality issues within the hospital and some audits had not been adapted to the model of care provided at the hospital.
- Managers did not oversee risks well. For example, the environmental checks did not identify all the shortfalls we found. We issued a warning notice to the provider to make sure they improved the governance arrangements.
- Managers had not resolved the minor shortfalls we found on the last inspection and resubmitted their action plan stating it would take longer to address these shortfalls.
- There was too much responsibility placed on one manager who carried both the registered manager and nominated individual role but also oversaw the running of another busy hospital.
- There was a hospital risk register in place which identified the two major systemic risks for this location relating to maintenance and the registered manager role but there was not appropriate and timely action to manage these risks.
- Staff did not know the provider's vision and values and how they were applied in the work of their team. The provider's vision and values did not fully reflect the model of care provided at Maryfield Court.

However:

- Most staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We have not carried out a Mental Health Act monitoring visit to Maryfield Court since the last inspection in February 2019.

On this inspection we found:

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- The provider had a Mental Health Act policy which clearly outlined the responsibilities of staff at each grade.
- Staff ensured that copies of patients' detention papers and associated records were stored.
- Most clinical staff had received training in the Mental Health Act.
- The hospital's Mental Health Act administrator was shared with Maryfield Court's sister hospital.
- At the time of the inspection, there was only one patient detained under the Mental Health Act. All the necessary legal paperwork was provided to ensure that the patient was lawfully detained. However, the corresponding outline approved mental health professional report was not available; the hospital was reliant on the referring hospital to provide this outline report.
- Staff explained to each patient their rights under the Mental Health Act in a way that they could understand and recorded it in the patient's notes each time.
- The independent mental health advocate attended the ward on an 'as required' basis following a referral.
- Staff ensured patients could take section 17 leave when this had been granted.
- Patients who were informal were informed of their rights to leave the ward.
- On one patient's care notes, agency nursing staff referred to the same patient as both detained and voluntary indicating that visiting agency staff may not be fully aware of each patient's status. We found this on the last inspection too.

Mental Capacity Act and Deprivation of Liberty Safeguards

On this inspection we found:

- Patients at Maryfield Court were usually detained and treatment decisions for mental disorder were under the Mental Health Act.
- We saw that patients' mental capacity to consent to their care and treatment had been assessed as required.
- Most staff received training relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The provider had a policy on the Mental Capacity Act. The policy included detailed checklists for the assessment of mental capacity for specific decisions and best interest considerations, where patients were assessed as lacking capacity. Staff could give examples of patients whose capacity had been assessed and best interest decisions taken to help and support patients.
- Informal patients who were consenting to stay at the hospital, were free to leave and were not subject to restrictions.
- The service had not made any Deprivation of Liberty Safeguards applications because patients at Maryfield Court were usually detained and receiving treatment under the Mental Health Act.
- The provider had a policy and a checklist for the consideration of Deprivation of Liberty Safeguards. The policy had been reviewed and reflected important case law.

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

Inadequate

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Good
Well-led	Inadequate

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Inadequate

Safe and clean environment

Maryfield Court was a hospital providing acute mental health care for adults of working age. There was a secure entrance to the building supervised by reception staff. It had four ward areas, known as apartments. There were two on the ground floor and two on the first floor. The wards that were in use at the time of inspection were apartments one and two, both on the ground floor. Each apartment had a communal lounge and dining area, a clinic room, and en-suite bedrooms rooms facing onto a corridor.

The hospital was meeting national guidance on providing same sex accommodation. Each apartment only admitted either male or female patients. Male patients had to walk through the top communal corridor area of apartment two, the apartment for female patients, to get to reception. However, all of the bedrooms had ensuite facilities. This meant that patients did not have to pass bedroom areas of patients from the opposite gender and their privacy and dignity was maintained. There was a lounge on each apartment so female patients had access to a female only lounge area. There were good lines of sight through the apartments. Where there were blind spots, which hindered staff observing patients, there were mirrors at height to help staff have a view of blind spots.

The wards areas were not fully safe or well maintained. Many patient bedrooms were not well maintained and not fit for purpose. The hospital had two operational apartments – apartments one and two. Twelve bedrooms out of 13 bedrooms in apartments one and two required some element of maintenance; six bedrooms had been identified by the provider as not fit for use.

- Five bedrooms were showing signs of damp with plaster coming off and bubbling paintwork. Radiator covers had been removed or damaged and not replaced leading to exposed metal casings in two bedrooms.
- Fixed furnishings or fixings had been damaged or come unfixed and been not repaired or replaced in six bedrooms.
- Six bedrooms had no blinds as the blind fixings were not in place. Some walls were heavily marked, stained or graffitied as to be unsightly in five bedrooms and most other bedrooms had walls with markings on them.
- One bedroom's locking mechanism was faulty.
- In two bedrooms the light sensors in the ensuite were not working.
- In two bathrooms the hot water was not working, or the plumbing was incorrect so that the sink tap flushed the toilet.
- In one bathroom the toilet was heavily stained.

Many of the maintenance issues had been caused by a small number of patients in May 2019 and June 2019 who presented with disturbed behavior and caused damage to the ward environments. At the time of the inspection there were only two patients at the hospital so only two of the bedrooms were in use. We could not view one occupied bedroom but it was reported that the light sensors in the ensuite was not working and there were marks on the walls of the bedroom and ensuite. There had been up to 12 service users during the weeks preceding our inspection, which meant that patients were admitted to the hospital and placed in bedrooms which required significant maintenance.

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

Inadequate

The provider had carried out regular ligature audits and identified ligature risks. Ligature risks were places to which patients intent on self-harm might tie something to strangle themselves.

We identified ligature and other environmental risks that the provider had not identified themselves. The upper windows in service users' bedrooms had a hinge restrictor mechanism that could be used as a ligature anchor point. This had not been fully detailed in the ligature risk audit and no proper action was taken to mitigate against this risk.

During our tour of the ward, we saw an electric socket in the lounge in apartment one which we found to be in use despite the socket casing coming off the wall significantly with exposed holes into the electric wiring. This had not been picked up at all by the provider checks, despite an environmental audit being carried out the day before our inspection. The provider addressed this on the first day of our inspection when we brought it to their attention.

The main door to the ward areas (at the entrance to apartment one) could not lock fully as the magna lock mechanism was faulty. It had been reported as faulty following a leak in May 2019. There was no clear detail in the maintenance log when the door would be fixed. The main door into the ward and patient areas was therefore unlocked, meaning staff did not have the facility to lock the doors as one element of mitigating the risks when they cared for patients who were detained under the Mental Health Act. During our inspection, staff were placed near the door to prevent patients leaving the wards and accessing off the ward into the reception area.

The wards areas were not fully clean. Bathroom floors across the bedrooms were dirty. There were significant marks or stains on the walls of all of the bedrooms. One of the patients who was there during the inspection, had gone absent without leave for three nights. The patient returned during the inspection, but their bathroom was visibly dirty and the toilet in the ensuite of that bedroom was soiled. The patient's bathroom had not been cleaned while they were absent without leave.

Detailed cleaning schedules had not been completed thoroughly since 4 March 2019 and therefore no detailed cleaning schedules had been completed from 25 May 2019 when the hospital reopened. Cleaning staff completed shortened cleaning schedule forms but these had no detail about the areas cleaned and very limited detail other than the date and a tick to say cleaning had occurred. Across all the shortened cleaning records since 4 March 2019 they stated 'n/a' (not applicable) under the any issues section. The hospital had a detailed cleaning record but this was not completed. One manager told us that they would accept detailed cleaning schedules to be completed retrospectively.

The fencing around the premises was easily surmountable and did not minimise the likelihood of unauthorised exit by service users. The door of the fence had a significant foothold meaning that service users could easily climb up the gate and leave the unit. Patients were also at risk of falling from height. There had been 10 incidents of patients going absent without leave directly from the ward since May 2019. Patients had supervised access to an external garden and courtyard area. Patients were able to scale the fencing and gate around the unit.

The hospital did not have a seclusion room and patients were not secluded in any other room in the hospital. There was a seclusion and segregation policy in place and an agreement with the commissioning NHS trust that any patient who became inappropriately placed would be discharged back into their care.

Clinic rooms across the apartments were clean and fully equipped and had available emergency resuscitation equipment. Equipment was calibrated and portable appliance tested. There was evidence that there were appropriate checks in place including clinic room and fridge temperatures, cleanliness and stock levels.

The emergency oxygen cylinder was not stored appropriately as it was stored behind a photocopier and water cooler in the reception area. This meant it was not easily accessible in an emergency but it was also stored next to electric equipment which could overheat. This posed a significant risk of a serious fire as oxygen is highly flammable. National guidance states that oxygen cylinders must be stored in a secure area that is well ventilated, clean and dry; and the area must be free from any sources of ignition such as machinery. The provider acted and moved the emergency oxygen cylinder to the clinic room by the second day of the inspection.

As a result of our concerns about the safety and maintenance of premises, the provider agreed not to admit any further patients and provided a detailed action plan in

response to a letter of intent we wrote raising urgent concerns. This action plan provided detailed and specific information of how the provider intended to improve the premises and maintenance.

As the premises were not clean, secure, properly maintained and meeting hygiene standards, we issued the provider with a warning notice and told the provider they must improve by 18 October 2019.

The provider continued with the voluntary undertaking not to admit any patients. Both patients at the hospital at the time of the inspection were discharged or transferred by 19 July 2019.

Safe staffing

The hospital also had a registered manager (who was also the nominated individual) and a head of care. They provided cover for short term unexpected absences.

At the time of the inspection, there was only two patients across both apartments. The staffing for these patients were one registered nurse and two health care assistants. The wards operated a two-shift system, a day and night shift. There was seven qualified nurses working at the hospital and one nurse vacancy; there were 16 support workers with no vacancies.

Managers looked at actual and expected staffing levels on a daily basis to ensure that the apartments were appropriately staffed and varied due to the number of patients at any given time. Staff worked flexibly across Maryfield Court and another hospital run by the provider to ensure that staffing levels were maintained. Managers could adjust staffing levels daily in response to ward activity, patient mix or clinical need. However, given the uncertainty of patient numbers due to the spot purchasing arrangements, this meant relying on agency and bank staff at times. Managers could access bank and agency staff to provide cover or increase staffing numbers when required.

The service had been reliant on bank and agency staff since reopening in May 2019. Of the total shifts between since reopening and June 2019, the staff consisted of:

- Permanent staff - 66%
- Agency staff - 26%
- Bank staff - 8%

There had been no incidents relating to staffing shortages reported in the hospital incident reports.

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward.

The hospital provided a mandatory training programme for all staff. Mandatory training covered a range of different areas including fire safety, first aid, health and safety. Mandatory training compliance for staff was at 81% which was just above the services target of 80% for all courses. Training included first aid, fire training, health and safety, infection control, intensive life support, safeguarding, diversity and equality and creative intervention training in response to untoward situations (CITRUS), which the service used for least restrictive approach to managing violence and aggression. All but one of the courses had good uptake levels. The course with the lowest uptake was intensive life support where three out of 9 relevant staff (67%) had not undergone recent training. However, all registered nursing staff working on the apartments had completed the training.

The hospital employed a consultant psychiatrist. At the time of the last inspection, the consultant worked five days on reduced hours with a whole time equivalent of 4 days a week. At this inspection, given the low numbers of patients, the doctor also carried out duties at the provider's other hospital. On call support was provided by the consultant psychiatrist or a locum when they were not available. Out of hours support for physical health care needs would be accessed through normal NHS services.

The post of the speciality doctor (whole time equivalent of 5 days a week) was vacant at the time of the inspection so the consultant psychiatrist was available to address patients' physical health needs.

Patients had one to one time with the nurse that was allocated to their care. In between these times, all other staff were available for patients to talk to if they so wished. Staffing was sufficient to be able to take patients out on leave from the wards.

Assessing and managing risk to patients and staff

Staff completed a risk assessment for each patient when they were admitted. Each patient had an initial 72-hour care plan which included a risk assessment in place. Staff managed risks through individual assessment. Staff used a recognised risk assessment tool. Staff assessed and managed risks using the 'standard tool for the assessment of risk' tool. Staff completed this electronically.

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

Inadequate

Staff could observe patients in all areas of the wards and followed procedures to minimise risks where they could not easily observe patients. Where patients were on higher levels of observations, staff provided a recorded rationale for the observations levels.

Staff were not always reviewing patients' risk assessments and management plans were not updated following incidents. We saw examples where patients' risk assessments had not been reviewed and updated following incidents, including verbal threats of arson, self-harm incidents, significant disinhibition and service users going absent without leave. Where risks were identified through risk assessments or incidents, care plans or management plans were not updated with detailed information to look at how staff could manage these risks.

We noted that service users' risk assessments were not updated following incidents of patients going absent without leave and that effective risk management strategies were not put in place. For example, one patient detained under the Mental Health Act absconded, but their risk assessment had not been reviewed since the incident. Another patient had attempted to abscond from the courtyard on the morning of and then successfully absconded from the courtyard twice in the same evening indicating that control measures were not put in place to mitigate the risks of the patient absconding. Staff did not always review risks to patients well to anticipate and managing challenging behaviour.

Staff did not always complete proper records following restraint incidents and managers did not review these fully. The hospital did not use restraint regularly. We saw that records relating to incidents of restraint were not fully effective to ensure that restraint was used in line with the Mental Health Act Code of Practice. We saw a small number of incidents indicated that restraint may have been used but there was limited information in the incident record and/or no corresponding restraint form to indicate what type of restraint was used, how long for and whether it was a proportionate response.

We were not assured that restraint incidents were properly considered by managers. We saw incidents where restraint may have been used had been signed by a nurse and a manager without evidence of further clarification being sought to fully clarify whether restraint was used with an appropriate corresponding restraint record or form being completed. The restraint form used had tick boxes for staff to categorise the type of restraint they used but the form did not provide the option of prone restraint for staff to identify and record if prone restraint was used.

Managers did not review incidents effectively and appropriate action was not always taken or recorded. We saw that there had been 10 incidents of service users going absent without leave. These incidents included service users scaling the fence or gate in the courtyard area and going absent without leave. Managers had known about this but had not taken timely action to address this and mitigate the risk such as fully addressing the significant foothold in the gate of the outdoor fence.

Staff did not take proper measures to control the risk of exposure to legionella bacteria. For example, there were a number of empty bedrooms with showers and taps, the completed records relating to the temperature checks only went up to March 2019. There were no recent records or operational system which was regularly and routinely used to ensure that hot water taps and the showers which were not being used were turned on, had their temperatures checked or flushed regularly to help prevent exposure to legionella bacteria. There was no provided evidence of legionella testing having taken place since March 2019 despite us requesting this.

The hospital operated a no smoking policy. Patients were offered support to give up smoking with routine assessment and support with nicotine replacement treatment and counselling to give up smoking. The practical implementation of the no smoking policy did not appear to be causing difficulties for patients and staff, except for the occasional incident of patients smoking in their bedrooms.

Patients were allowed to have mobile phones and were not subject to blanket restrictions. There were a small number of items which were not allowed in patients' bedrooms and these were locked away and available on request. Individual patients were assessed around any items of personal belongings that may need to be considered for confiscation; the need for searching patients was made on an individual basis.

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

Inadequate

Safeguarding

There had been two safeguarding referrals or notifications since the last inspection. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse.

We identified one incident where staff may have not fully protected a former patient from abuse.

We saw that staff had identified unexplained bruising to one patient three days after their admission. Staff had not considered this as a safeguarding incident. It was not reported or investigated. A manager had signed off the form, stating they noted the unexplained bruising. There was no clear evidence from the records that the patient had undergone or was offered a physical assessment on admission, meaning that managers did not fully assure themselves that the bruises had not occurred while the patient was in their care and had not taken appropriate action to ensure this was looked into when the bruising was identified.

The provider had its own safeguarding policy and procedure. The policy guided staff to follow the local safeguarding procedures. There were posters displayed for patients to inform them of safeguarding, their right not to be subject to abuse and how to raise a safeguarding alert. As a result of us raising the incident of unexplained bruising, managers had produced additional guidance to staff and were providing additional training to staff.

Staff could describe the safeguarding reporting process in the hospital. Staff described that they reported any incidents to the head of care or registered manager. Seventy-eight per cent of relevant staff had undergone recent safeguarding training.

The hospital had a visiting room off the ward apartment areas. This meant that children could visit without going onto the main ward area. The room used had not been adapted to make it welcoming to visiting children and young people.

Staff access to essential information

Patients clinical information was recorded in several places and it was not always easy for staff to maintain high quality clinical records. Staff used a combination of electronic and paper records at Maryfield Court. The electronic recording system was developed by the provider and contained daily records, one to one sessions and doctor's notes. Referrals, admission documents, care plans and assessments, physical health checks and other professional records such as occupational therapy plans were recorded elsewhere. This had already been identified by managers who had requested an updated electronic record keeping system to incorporate all documents. However, staff could show inspectors where records were kept and how to access them.

At the last inspection we found that agency staff used the same access code when entering the electronic care record system. This meant that all agency staff had the same identification code automatically generated against each entry making it difficult to identify who had made what entry if they had not included their name at the end of the entry. On this inspection, we saw that managers had been some improvements but this still had not been fully addressed. We sampled daily record entries in patients' notes and saw that out of 23 records made by agency staff, 18 recorded the name but five records had no name added to identify the specific agency member of staff making the written entry in the patients' records. The provider resubmitted their action plan stating they would resolve this by the end of August 2019.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff reviewed the effects of each patient's medication on their physical health according to the National Institute for Health and Care Excellence guidance. There were no patients on high dose anti-psychotics and staff had guidance and a ready reckoner to check whether doses exceeded maximum recommended levels. Basic physical health checks were completed when patients were admitted. The prescribing clinician reported that they carefully reviewed patients' medication and weighed up the benefits and risks prior to prescribing medication and records corroborated this.

The prescription charts were up-to-date and clearly presented to show the treatment patients had received. Where patients had been prescribed 'as required' medication, there was an appropriate individualised protocol to guide staff when and how staff should administer 'as required' medication.

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

Inadequate

The ward was supported by a visiting pharmacist who completed regular checks of the prescription charts which showed good adherence to good medicines management practices. Staff had access to guidance on prescribing medicine.

Medications were stored appropriately in a securely lockable room on each apartment within a locked cupboard. Stock levels of medication were audited regularly. There were processes for the management of medication, which included prescribing, ordering, storage, administration and disposal.

There were controlled drugs on site and we saw that the type and number of controlled drugs was properly accounted for in a controlled drug register. Controlled drugs are medicines that require extra checks and special storage because of their potential for misuse. There was a controlled drugs accountable officer at the hospital whose role included ensuring that proper systems were in place when controlled drugs were prescribed.

On occasions, patients may be prescribed medication known as rapid tranquillisation to help with extreme episodes of agitation, anxiety and sometimes violence. The provider had an up to date policy covering this type of treatment. Following rapid tranquillisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate.

We saw that there had been one recent episode of rapid tranquilisation on a former patient since May 2019. The provider had a policy on rapid tranquilisation but there was no appropriate proforma for staff to complete to ensure appropriate observations were made. The corresponding care record for the former patient who had been given rapid tranquillisation were not available. Other records showed that observations had been attempted but refused and then the patient was asleep. When the patient refused these observations, staff had not recorded vital signs that they could observe visually within the available records. In addition, the hospital did not stock remedy medication (Flumazenil) that needs to be available where rapid tranquilisation is used despite the provider's policy stating that this needs to be available and given in the event of respiratory collapse.

Track record on safety

We looked at the incidents that had occurred recently at Maryfield Court. All independent hospitals are required to submit notifications of incidents to the CQC. The hospital had notified us of relevant events including incidents which involved the police where, for example, detained patients had gone absent or failed to return from authorised leave.

In the period from May 2019 (when the service reopened) to early July 2019, there were 55 incidents. These were categorised and included:

- Property damage - 16 incidents (29%)
- Patients going absent without leave through escaping - 10 incidents (18%)
- Harm to others physical 6 incidents - (11%)
- Harm to others non - physical - 4 incidents (7%)
- Security - 4 incidents (7%)
- Clinical - 3 incidents (5%)
- Patients going absent without leave through not returning – 1 incident (2%)

There had been no serious incidents recorded which required investigation within the service.

Managers produced a report which looked at the types and numbers of incident occurring at the hospital. The day and times of the incidents were reported and analysed to show any patterns of incidents based on times of the day or days of the week.

Reporting incidents and learning from when things go wrong

Incidents were recorded on a paper incident recording system. Managers reviewed these regularly and at least weekly and in the case of serious incidents they were also reviewed by the nominated individual/registered manager. Depending on the severity of the incident, incidents could also be reviewed by the board.

However, we saw that managers were signing off incidents without fully considering the need to take appropriate action, including clarifying aspects of the incident or escalating the concerns. For example, restraint records were not fully completed and these were signed off, incidents where restraint was likely given the circumstances but with no detail and the incident of unexplained bruising.

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

Inadequate

There had been no incidents at the hospital that reached the duty of candour threshold of moderate or severe harm at Maryfield Court. The hospital had a policy in place to support staff if such an incident arose.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

While staff assessed the physical and mental health of all patients, the care plans they developed were not always individual to each patient. Care plans were not always holistic and recovery-oriented. All the care plans staff completed were formulaic and were not always fully personalised. For example, on one ward we saw care plans relating to patients' mental health needs which were very similar despite patients on the wards having differing needs and long-term conditions. On one care plan, for a female patient, the patient was referred to as 'he' and 'him' throughout indicating that staff had not individualised the care plan. Some patients did not have a care plan other than a 72-hour care plan even though they were at the hospital longer than this.

Care plan records did not easily identify where the patient was in their progress towards discharge. However usually the ongoing running records and multidisciplinary meeting records provided more detail on the care, treatment and discharge progress and plans.

Patients' care and treatment were reviewed weekly. Patients' care and treatment needs were reviewed on a regular basis at multidisciplinary meetings. The multidisciplinary meetings considered mental health, physical health, legal status, capacity and discharge planning.

The systems had not been improved to ensure patients' physical health needs were met appropriately. At the last inspection, we found that staff did not complete physical health screening assessments including the taking of full histories from patients on the day of admission but staff were taking basic vital signs such as temperature, blood pressure and pulse.

On this inspection, we found staff were still not completing full physical health screening including the taking of full histories on admission (sometimes known as 'clerking in'). Staff were still taking patients' basic physical health baseline assessments carried out on admission to the ward and ongoing physical health checks. The doctor we spoke with explained that there was no other substantive medical cover to carry out the clerking in of patients when they were admitted. There were no other arrangements put in place by the hospital to make sure patients were offered a full medical check.

The doctor explained that most patients came from another hospital or were transferred from a health-based place of safety or an emergency department. Therefore, doctors at Maryfield Court relied on any physical health checks carried out prior to patients' admissions. These arrangements did not provide assurance that any changes in patients' physical health, including any injury during conveying the patient to Maryfield Court would be properly considered and addressed. Managers had not resolved this minor shortfall we found on the last inspection. Managers resubmitted their action plan stating it would take longer to address these shortfalls and aim to address the shortfall by the end of August 2019. The provider stated in the action plan that they would need to recruit a junior doctor or physician associate prior to re-opening Maryfield who would oversee all physical monitoring.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Staff at the hospital provided a range of pharmacological, nursing, psychological and occupational therapy interventions. Patients had access to treatment for common conditions such as schizophrenia or severe depression. Patients were treated with anti-psychotics where appropriate and doctors used National Institute for Health and Care Excellence to decide on the most appropriate treatment. For example, doctors did not usually prescribe anti-psychotics over maximum dosage guidelines, unless there was a clear individual clinical need.

Patients had access to psychological interventions available as there was a ward-based designated clinical psychologist. Patients had direct access to short-term focused psychological approaches whilst being an in-patient on the apartments as guided by the National

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

Inadequate

Institute for Health and Care Excellence on best practice treatment for depression, psychosis and self-harm. This meant staff considered what was the most appropriate and targeted interventions they could provide given that patients only usually stayed at the hospital for a short time.

When patients were admitted, the occupational therapist worked with patients to identify their occupational activity and needs matched with a completed interest checklist. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Staff supported patients to live healthier lives for example, through participation in smoking cessation schemes, healthy eating advice, and managing cardiovascular risks. The specialist doctor at the hospital was available for all physical health care needs.

Staff participation in clinical audit, benchmarking and quality improvement initiatives was limited. Staff completed local audits including looking at staff practice in relation to a number of limited areas such as clinic room, medicines management, mattress checks, nurse call alarms and key safety. Where minor shortfalls were identified, we saw that managers had sent out emails to staff to try and address the shortfalls. Managers at the hospital had audit plans in place to ensure that wider aspects of the running of the hospital were reviewed. These included a care planning audit, physical observations audit, section 17 leave audit, and health and safety in relation to incidents audit. These had not been completed. For example, the care plan audit had not been completed because managers said it had been developed for the provider's other hospital which was a longer stay hospital for people with autism and had not been adapted for the model of care of providing short term acute admissions at Maryfield Court.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. These included nurses, healthcare assistants, an occupational therapist, a clinical psychologist and a consultant psychiatrist. An external pharmacist visited the hospital twice a week. At the time of the inspection, the occupational therapist and clinical psychologist had recently started work and therefore were getting to know the hospital before developing programmes of interventions including working with staff to formulate appropriate care interventions and assess risk.

The provider had a corporate induction, which new staff attended. Agency staff also received an induction to the hospital.

Managers made sure they had staff with a range of skills needed to provide good quality care. Staff could show they had expertise to support patients' recovery and address patients' individualised needs including mental health and physical health promotion, the legal frameworks, recovery approaches, and discharge planning.

Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Staff we spoke with told us they received regular supervision and that they found it meaningful. Staff received clinical supervision, and at the time of the inspection compliance with supervision across the service was 89% and appraisal rates were at 100%.

Although managers ensured that staff had access to regular team meetings, these were not fully effective to drive improvement in the hospital. There had been two staff meetings since the hospital reopened. These were minuted – the meetings consisted of a limited number of discussions about specific, reactive matters that had been identified by staff or needed to be addressed with them. The meetings were not therefore formulated into proper meetings to inform staff and drive improvement through looking at a range of clinical governance items.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff told us they attended external courses leading to further qualifications.

Multidisciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Patients were discussed at regular twice weekly multidisciplinary meetings. Professionals routinely considered patients' holistic needs. The multidisciplinary meetings we observed followed a structured approach. There was good communication and a respectful attitude between multidisciplinary members. Staff showed a warm manner towards the patient in their care.

The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. There was evidence of good communication with local authorities,

community mental health teams and social services. Staff from community mental health and crisis teams were regularly invited and attended multidisciplinary meetings. We saw that where appropriate, staff referred patients to external teams. Other professionals would attend if required and carers described attending these meeting to discuss treatment options.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. The provider had a Mental Health Act policy which clearly outlined the responsibilities of staff at each grade. Staff on the ward told us they received appropriate support on matters relating to the Mental Health Act when required, including access to the Mental Health Act Code of Practice and detailed reference material. Staff ensured that copies of patients' detention papers and associated records were stored.

Most clinical staff had received training in the Mental Health Act which was mandatory and refreshed on an annual basis. At the time of the inspection the percentage of eligible staff trained was 81% which was above the hospital target of 80%.

The Mental Health Act administrator was shared with Maryfield Court's sister hospital. The administrator had a lead role in maintaining processes and systems to support compliance with the Mental Health Act and the associated Code of Practice. The Mental Health Act documents appeared to be correct and valid. Mental Health Act section expiry dates were within statutory timeframes. Regular audits were undertaken.

At the time of the inspection, there was only one patient detained under the Mental Health Act. All the necessary legal paperwork was provided to ensure that the patient was lawfully detained. While detention papers were in order, on this record, we did not find evidence of the corresponding outline approved mental health professional reports alongside the detention papers to fully understand and check the decisions made to compulsorily detain patients. Most patients were detained prior to coming to Maryfield Court, the hospital was reliant on the referring hospital to provide this outline report.

Managers made sure that staff could explain patients' rights to them. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand and recorded it in the patient's notes each time. There was a system in place to ensure that patients were given information about their legal status and rights on admission and at monthly intervals. Both patients confirmed that staff spoke to them about their rights as a detained patient and informal patient respectively.

Staff informed qualifying detained patients of their right to see the independent mental health advocate. Posters were displayed on the ward containing information about the independent mental health advocacy service. The independent mental health advocate attended the ward on an 'as required' basis following a referral.

Staff ensured patients could take section 17 leave when this had been granted.

Patients who were informal were informed of their rights to leave the ward. There were signs by the ward entrances to inform informal patients who were deemed to have competence or capacity that they could leave the ward. Records indicated that informal patients had been offered time off the unit.

On one patient's care notes, agency nursing staff referred to the same patient as both detained and voluntary indicating that visiting agency staff may not be fully aware of each patient's status. We found this on the last inspection too.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act applies to people aged 16 years or over.

Patients at Maryfield Court were usually detained under the Mental Health Act and treatment decisions for mental disorder for these patients were therefore made under the legal framework of the Mental Health Act. We saw that patients' mental capacity to consent to their care and treatment had been assessed as required.

Staff received training relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of the inspection the percentage of eligible staff trained was 77% which was just below the hospital target of 80%. Staff had access to the Mental Capacity Act and Deprivation of Liberty Safeguards codes of practice.

The provider had a policy on the Mental Capacity Act. The policy included detailed checklists for the assessment of mental capacity for specific decisions and best interest

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

Inadequate

considerations, where patients were assessed as lacking capacity. Staff could give examples of patients whose capacity had been assessed and best interest decisions taken to help and support patients.

Informal patients who were consenting to stay at the hospital, were free to leave and were not subject to restrictions.

The service had not made any Deprivation of Liberty Safeguards applications since the last inspection. This was because patients at Maryfield Court were usually detained and receiving treatment under the Mental Health Act or they had capacity to agree to hospital admission. The provider had a policy and a checklist for the consideration of Deprivation of Liberty Safeguards. The policy had been reviewed and reflected important case law.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. Both patients told us they felt able to approach and talk with staff and they felt listened to. They also both felt the doctor was approachable. Both patients liked the hospital and felt that it was much better than other busy acute mental health admission wards they had been on in other hospitals. We spoke with one carer who told us that they were pleased with the care staff provided. Although our observations were limited due to the small number of patients at the hospital and the layout of the apartments, we observed staff treating patients with respect and dignity.

Staff respected patients' privacy and dignity. Both patients we spoke with told us that nursing staff were respectful and polite. Staff spoke about patients in a respectful manner.

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients felt they received support to help them with their recovery from mental ill-health. One patient told us that they were given information on the benefits and side effects in a way they understood.

Involvement in care

On admission patients were orientated to the ward by staff and patients were given information about their care and treatment. Patients were also given a detailed welcome pack and staff explained the ward, how it operated and what was on offer.

Staff did not always show how they involved patients in care planning and risk assessment. Patients told us they felt involved in the decisions about their care and treatment. Patients were encouraged to attend multidisciplinary team meetings to discuss their ongoing treatment.

However, all six records we looked at did not indicate that patients were involved in the planning of their own care and treatment. Care plans drawn up at initial 72-hour assessment often nurses stated that the patient was too unwell to engage or gave some other reason for not involving the patient.

Care plans reflecting ongoing treatment also gave similar reasons for the patient not being involved or did not state whether the patient had been involved (with the section on the care plan form left blank). In one such case, there was other evidence in the records which suggested that the patient could contribute meaningfully in the identification of their own needs and planning of care. In addition, the patients' voice or contribution was not fully evidenced in the written care plan as they were written from the nurse's perspective. None of the six records showed that patients had been given or offered a copy of their care plan.

The provider had not carried out any recent care plan audits to identify and address the lack of recorded patient involvement in patients' care plans.

During our observations of the multidisciplinary meeting, we saw that members of the multidisciplinary team made efforts to involve the patient in their own care, treatment and decisions. However, the one issue raised by the patient at the meeting, was not fully or explicitly addressed in the meeting.

Managers collected patient feedback using different methods. The apartments displayed 'you said; we did'

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Inadequate

information telling patients what action had been taken following patients raising minor concerns or suggestions to staff. Recent examples of staff acting on patients' comments included purchasing a toaster and improved hot drink making facilities in each apartment.

Patients could complete satisfaction surveys. The results for June and July 2019 showed that of the nine patients that responded, most were happy with the care and treatment they received. High scoring questions included patients confirming they were shown round the unit, the doctor discussing the treatment and detained patients being informed of their rights (all with 100%); lowest scoring questions were patients not being offered psychology input within 72 hours (44% of respondents – although a clinical psychologist had since been appointed) and cleanliness with 25% reporting cleanliness was OK (rather than good) and 12% reporting cleanliness as poor. Patients identified three things they didn't like - night staff, poor communication and staff not being trained well. Managers had not clearly stated what action they would take within the survey report to address these concerns raised by patients. However we did see that managers had taken action into one of the concerns as they had spoken with night staff in community meeting records.

There had been plans to have weekly community meetings that patients could attend but this depended on the number of patients at any given time. There had been one community meeting on each apartment since the hospital reopened. These meetings gave a space for patients to raise issues with staff about the running of the wards, such as hospital maintenance, activities, food and staffing. Staff had recorded the action upon issues raised by patients. Some issues had been addressed. For example, patients commented that night staff could be more approachable and this was raised with staff at the staff meeting to ensure staff reflected on how their attitude was viewed by patients. However not all issues raised by patients had been resolved such as the need for the hospital to be repainted. Many issues had been referred to the head of care but there had been no further meetings to consider these issues and feedback to patients formally.

Staff ensured that patients had easy access to independent advocates. Patients were informed about the advocacy service. Patients had access to advocacy by referral when they were inpatients, including specialist advocacy for patients detained under the Mental Health Act known as independent mental health advocates. Patients we spoke with were aware of the independent mental health advocacy service.

Involvement of families and carers

Staff informed and involved families and carers appropriately. The carer we spoke felt they were given appropriate information and were involved in the patient's care and treatment. Patients were encouraged to involve relatives in their care and treatment if they wished. Carers were invited to multidisciplinary review meetings to give their views about the care, treatment and recovery of their relative. However sometimes this was impractical depending on the distance the patient was from their home area. Carers were informed when important events or incidents occurred such as when patients went absent without leave.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Staff managed referrals well and worked with bed managers in the local NHS trusts. Patients were referred to Maryfield Court when there was no mental health acute bed available in their local area. At the time of the inspection, three NHS trusts were using Maryfield Court on a spot purchase bed. Two of these were in the North West of England and one in the Midlands. Staff worked with local NHS trust bed managers to secure a bed for patients when there was not an acute admission bed locally.

Referrals could be made at any time of day and decisions were made quickly. There was a manager's triage system in place during office hours to decide on the suitability of the patient referral. The senior nurse in charge considered and accepted referrals out of hours. There was agreed admission criteria between the trusts and the hospital to ensure only patients suitable for the hospital were referred.

The hospital did not have a psychiatric intensive care unit or seclusion facility. Where patients' needs showed that they may require more intensive support and care or where

they may require seclusion, they would not be admitted. Staff worked with NHS staff to transfer patients if the patient's needs changed to the extent that they become unsuitable for Maryfield Court.

The average length of stay was 10 days. Patients either returned to a bed in a hospital run by their local NHS mental health trust or could be discharged back home with community mental health service support. Staff worked with NHS staff to ensure patients were transferred to their local hospital when there was a local bed available. When patients were ready for discharge and did not require hospital admission, staff worked with community mental health staff if patients were ready.

The bed occupancy for the period since the hospital reopened in May 2019 was 56%. Patients could always return to their own bedroom after going out on leave as their bed was not reallocated until a patient had been discharged.

There had been no incidents of delayed discharge (such as patients being ready for discharge but not being able to leave hospital) since the hospital reopened in May 2019. The hospital provided beds when no local beds were available and patients were quickly transferred back when a bed became available. Neither of the patients at the hospital were delayed discharges.

Staff planned and managed discharge well. They liaised well with services that would provide aftercare. As a result, patients' discharge was rarely delayed for other than a clinical reason.

Staff discussed and considered discharge planning with patients and community team staff at regular intervals. Patients' discharge was discussed at multidisciplinary meetings which took place twice weekly. Both patients we spoke with could provide information about their own discharge plans. Where patients were discharged, these were planned to occur and patients were informed.

Staff at Maryfield Court worked to ensure that patients were informed and supported to be transferred. Sometimes, staff got very little notice when NHS staff made decisions about patients transferring back because NHS staff had found a local bed. In these cases, staff worked to prepare patients who needed to be transferred quickly, as much as possible.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom. All bedrooms were en suite containing a toilet and a shower. Most bedrooms were unoccupied but they appeared stark with limited furniture, basic colour palettes and no homely touches such as paintings, murals or noticeboards.

Each bedroom had the facility for secure storage through a lockable drawer in their bedroom but staff did not have the key for all the lockable drawers as some had been lost. Patients could personalise their bedrooms with their belongings and decorations. Each apartment had a lounge and dining area.

While some bedrooms were not properly clean or well maintained, these areas were not in use and were locked off so current patients could not access them; the communal areas were comfortable and mainly clean and well maintained. We report on cleanliness and maintenance in the 'safe' key question section.

There were quiet areas on the apartments. The unit also had a large activity room and a family meeting room for visitors and children. Patients could make a phone calls in private. Both apartments had a separate clinic room for physical examination and care.

Each apartment had a secure outside space. Patients had access to a large garden area, although doors to the garden were kept locked so patients had to ask staff to let them out and patients were supervised while outdoors.

Patients could keep their mobile phones and any restriction to the use of mobile phones was following an individual risk assessment. Although wi-fi was not provided by the hospital, patients had access to laptops in the activity room on which they were able to access the internet.

The hospital was no-smoking so those patients who smoked had to go outside the hospital. Patients were offered support with smoking cessation.

The food was of a good quality and patients could make drinks and snacks at any time. Food was cooked fresh on the premises and patients were very complimentary about the standard of food available to them. Patients had access to hot drinks and snacks at all hours on the apartments.

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

Inadequate

Patients' engagement with the wider community
Patients had access to an activity and therapy programme which patients were encouraged to participate in. This included walking groups into the local community as well as baking and breakfast club groups to help patients remain independent while at Maryfield Court.

Patients had autonomy and choice over how they spent their day. There were a range of communal and quiet spaces which patients could use without restriction.

Patients were encouraged to keep in contact with family and friends. Patients were also supported to utilise leave to go out into the wider community and visit family and friends, where possible.

Meeting the needs of all people who use the service
The service met the needs of all patients who used the service – including those with a protected characteristic.

The hospital was accessible to patients with physical disabilities, with ramped access into the building, level access throughout the apartment and a working lift to all floors. Parking included designated parking bays directly outside the building so that patients or visitors with limited mobility did not have to walk far to get to the apartments. Many of the bedrooms were spacious with space to use a wheelchair. Toilets and showers were not adapted fully as they did not have handles; however, managers stated they could fit appropriate equipment based on the assessed needs of individual patients.

Staff helped patients with communication, advocacy and cultural and spiritual support. Information for patients was posted on notice boards to ensure patients were informed on what was available in the hospital, how to make a complaint, advocacy services, and local services.

Managers made sure staff and patients could get hold of interpreters or signers when needed. Interpreters were available to staff when required by either using the contract the NHS trust had to provide staff trained in interpreting or through a contracted telephone interpreting service, if a patient or carer's first language was not English. Some staff were fluent in other languages, such as French, so could speak to patients directly in their preferred language.

Staff provided a range of food to patients to meet their dietary requirements and cultural needs. Patient feedback was sought on the range and quality of the food provided.

The hospital did not have a multi-faith room. Patients had access to spiritual support through attending local places of religion if they had leave out of the hospital or through on an individualised assessment.

Listening to and learning from concerns and complaints
The service treated concerns and complaints seriously, investigated them and learned lessons from complaints outcomes, and shared these.

Patients were given written information about making complaints within the hospital booklet when they were admitted. This included details of how to raise concerns locally to help ensured complaints were resolved. Information on complaints and the Care Quality Commission's role in complaints were displayed on the apartment. However, a locally devised poster about complaints told patients they could appeal to the CQC if they were not happy that their complaint had been resolved. The CQC only consider individual complaints from patients where they wish to complain about the use of the Mental Health Act.

Detained patients qualified for support from an independent mental health advocate. Posters were displayed on the apartments containing information about the independent mental health advocacy service.

The service received a low number of complaints. At the last inspection, we saw that there had been seven complaints received by the hospital since it opened and all complaints had been investigated. On this inspection, we saw that there had been one further complaint which the managers at the hospital were still looking into.

Staff knew the complaints process and policy.

The hospital used 'you said, we did' which showed that they listened to patient concerns and looked to address these.

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

Inadequate

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Inadequate

Leadership

The registered manager had many years of experience managing mental health hospitals within the independent sector. However, at the time of the inspection, they were acting as the registered manager for another hospital run by ASC Healthcare Ltd for patients with complex autism needs. The hospitals were geographically distant by 17 miles and the registered manager was working between the two hospitals. This same person was also the nominated individual for the company. The nominated individual is a role in law who represents the provider nominated by the organisation to carry out this role on their behalf. The nominated individual is responsible for supervising the management of the regulated activity. The number of responsibilities falling on this one person was identified on the corporate risk register but the risks were poorly mitigated.

The wards were managed by day to day by the head of care who led the nursing team and ensured the complex needs of the patients were met.

Leaders understood the service they managed and knew how their teams worked to provide high quality care. Senior managers were sighted on most issues within the hospital and were trying to work to address these. However, the registered manager/nominated individual did not have full autonomy and had to await board decisions on strategic and operational issues such as ongoing building maintenance.

The provider did not have robust and effective governance systems in place to ensure ongoing oversight. The hospital had introduced electronic recording systems which, when properly implemented would assist managers to understand what each apartment did well and the pressures faced by ward staff. However, many tabs within the electronic recording system were not being fully utilised and the provider was still operating some paper records and the older system using computerised folders which did not support ongoing oversight.

Patients and staff told us that they knew who the managers were, could approach them and saw them often in the service. Most staff were positive about the head of care and registered manager, describing them as approachable and felt that managers listened to them.

The board met quarterly to discuss clinical, personnel and finance matters relating to each hospital. There was a board meeting in April 2019 when Maryfield Court was closed. At the April 2019 board meeting, there were discussions about improved subcommittee structures and reporting arrangements but these changes had not been fully implemented.

Vision and strategy

The provider, ASC Healthcare Ltd, had the following mission:

"Through our unique delivery of a social and clinical partnership model, we will actively support individuals to develop a range of life skills and functional strategies. These will allow individuals to live the life they want to live now and in the future.

We recognise and endorse the philosophy that a hospital is not a home, but a place for extra support, during a critical time in a person's lifetime. The emphasis of our work from point of referral will always focus on discharge preparation."

They had also developed a framework of 11 behaviours and values detailed on their website.

We have summarised the values as they were written in detail and were not easy to read or assimilate:

- a focus on people's strengths.
- assessment and planning beginning prior to admission and consistently informed by evidence-based practice.
- clinical expertise, specialist knowledge and research underpinned by excellence and a positive learning culture philosophy.
- quality at the forefront of everything and working towards accreditation by the National Autistic Society Accreditation Service.
- all patients were central and empowered in making meaningful judgements and choices as a valued partner.
- a balanced positive approach to risk exposure

- seeking the views and experiences of patients, their families, and others to inform and influence the service delivery.
- a multidisciplinary team approach
- staff approaches which look behind what they see and hear, avoiding neuro-typical interpretations and to recognise the underlying or intended meaning of behaviour or communication.
- embracing the four key principles of rights, independence, choice and inclusion as defined in the Valuing People Strategy for People with a Learning Disability (2001).
- The European Charter for Persons with Autism (1996) will be adopted and will inform the culture of the organisation and its services.

The values were largely drawn from the model of care provided at a hospital for people with autism also run by the provider.

All the frontline care staff we spoke with were not aware of the mission or values of ASC Healthcare. While staff described a patient-centred service which sought to empower patients and worked towards discharge, the written plans of care did not fully evidence the provider values in the same way because of the lack of recorded patient involvement or patient strengths.

Culture

Most staff reported feeling respected, supported and valued by managers who were approachable. Most staff felt positive about working at the hospital. Staff described good working relationships with managers and with other members of the multidisciplinary teams.

Staff felt able to raise issues and escalate concerns without fear of retribution. Staff were aware of the whistleblowing process and would be happy to follow it if required.

Governance

The governance arrangements and routine checks were either not in place or not effective.

- The system for ensuring ongoing maintenance of the premises was poor – some issues had been reported in 29 May 2019 and no action had been taken to fully address the maintenance job. Many of the maintenance jobs identified were added onto the electronic maintenance system on 14 July 2019 despite it being clear that the maintenance being required well before that time tracked against incidents of service uses damaging property. Other issues, including the electric socket in the men's lounge which we found to be in use despite the socket casing coming off the wall, had not been picked up at all, despite an environmental audit being carried out on 14 July 2019. This showed that the provider's own checks were not sufficiently robust and where they assessed and identified shortfalls in the maintenance, they did not take timely action to mitigate the risks fully.
- The system for ensuring the risks relating to the proper storage of medicines and medical gases was not effective and did not follow national guidance. National guidance states that oxygen cylinders must be stored in a secure area that is well ventilated, clean and dry; and the area must be free from any sources of ignition such as machinery. The emergency oxygen cylinder was not stored appropriately as it was stored behind a photocopier and water cooler in the reception area which could overheat. This posed a significant risk of a serious fire as oxygen is highly flammable. Although the cylinder was moved immediately, the provider's checks did not identify the inappropriate storage of this medical gas. In addition, we saw that there was one episode of rapid tranquilisation used but the hospital did not have stock of Flumazenil in line with the hospital's own policy and national guidance.
- The systems for assuring the cleanliness of the premises was poor. Detailed cleaning schedules had not been completed thoroughly since 4 March 2019 and therefore no detailed cleaning schedules had been completed from 25 May 2019 when the hospital reopened. The shortened cleaning schedule form that had been completed but had no detail about the areas cleaned and stated n/a (not applicable) under the any issues section. One manager told us that they would accept detailed cleaning schedules to be completed retrospectively. We found areas of the hospital to be visibly dirty, including bathrooms in all the bedrooms and one patient's bedroom was found to have not been fully cleaned during their absence and was still dirty on their return.
- Effective systems and measures were not in place to control the risk of exposure to legionella bacteria. For example, there were a number of empty bedrooms with showers and taps, the completed records relating to the temperature checks only went up to March 2019. There were no recent records or operational system which was

regularly and routinely used to ensure that hot water taps and the showers which were not being used were turned on, had their temperatures checked or flushed regularly to help prevent exposure to legionella bacteria.

- The systems to review records relating to incidents of restraint were not fully effective to ensure that restraint was used in line with the Mental Health Act Code of Practice. We were not assured that restraint incidents were properly considered by managers. We saw incidents where restraint may have been used had been signed by a nurse and a manager without evidence of further clarification being sought to fully clarify whether restraint was used with an appropriate corresponding restraint record or form being completed. The restraint form used had tick boxes for staff to categorise the type of restraint they used but the form in use did not provide the option of prone restraint for staff to identify and record if prone restraint was used. This meant that the provider did not have effective systems to record and monitor restraint episodes and mitigate the risks to health, safety or welfare of service users receiving inappropriate restraint.
- The systems to review incidents were not effective and appropriate action to mitigate the risks relating to service users' health and safety were not always taken or recorded. We saw that there had been 10 incidents of service users going absent without leave. These incidents included service users scaling the fence or gate in the courtyard area and going absent without leave. Managers had known about this but had not taken timely action to address this and mitigate the risk such as fully addressing the significant foothold in the fence. We also saw examples where service users' risk assessments had not been reviewed and updated following incidents, including verbal threats of arson, self-harm incidents, significant disinhibition and service users going absent without leave.
- We were not assured that safeguarding arrangements were sufficiently robust. We saw that staff had identified unexplained bruising to one patient three days after their admission. Staff had not been considered this as a safeguarding incident. It was not reported or investigated. A manager had signed off the form, stating they noted the unexplained bruising with no further action evident by speaking with managers and looking at the records.
- The provider had also not addressed the areas of non-compliance we found on the last inspection in a timely manner. We saw that service users had basic baseline physical health checks on admission but did not have or were not offered a proper medical check as part of the admission clerking in and also we continued to find examples of agency staff not adding their name or details onto care records entries in five out of 23 entries we reviewed.
- The completed audits were limited in scope and failed to identify all of the issues we found on inspection. The hospital had an audit cycle but this was not fully followed. Some audits, such as the care plan audit had not been completed because managers said it had been developed for the provider's other hospital which was a longer stay hospital for people with autism and had not been adapted for the model of care of providing short term acute admissions at Maryfield Court.

As a result of our concerns about governance, the provider agreed to not admit any further patients and provided a detailed action plan in response to a letter of intent we wrote raising urgent concerns and considering urgent action (section 31 of the Health and Social Care Act). The provider also resubmitted their action plan following the last inspection. This provided detail of how the provider intended to improve the governance arrangements.

This meant that there was no effective governance system in place at the time of the inspection. Therefore, care and treatment was not always provided in a safe way for service users. This was because the governance system were not effective in identifying, assessing or mitigating risks relating to the health, safety or wellbeing of service users which was a breach of regulation relating to good governance. We issued the provider with a warning notice and told the provider they must improve by 30 August 2019.

The provider continued with the voluntary undertaking not to admit any patients and both patients at the hospital were discharged or transferred by 19 July 2019.

Management of risk, issues and performance

Managers kept a risk register which identified risks to patients or staff which were escalated to the board. The current risks identified were:

- the high volume of environmental damage due to the challenging nature of the patients, which could impact on environmental safety ,e.g. loose fittings and the poor state of furniture which was placed on the risk register on 10 April 2019, and

- one person acting as registered manager, CQC nominated individual and chief executive officer. This could cause blurred leadership and lines of reporting thereby affecting quality of service delivery. This was placed on the risk register on 3 May 2019.

The risk register had details of how these risks could be mitigated. However, progress in addressing these areas was recorded as slow and the initial and current risk scoring remained high with the same score of 20 (which was the second highest score below catastrophic risk of 25) because the controls were not sufficient to mitigate the risks.

The first risk relating to maintenance indicated that the number of maintenance tasks was too much for the employed maintenance person and there was a lack of a longer-term plan for maintenance. The risk register indicated that managers had escalated this to the board but were awaiting the board's decisions on maintenance approval and investment.

The second risk relating to too much responsibility falling on one person was detailed in the risk register with mitigation reliant on the long-term plan to recruit registered managers with no interim arrangements to mitigate these risks. This meant that while strategic risks were identified, staff and board members were not taking appropriate and timely action to address or reduce the risks, including interim measures or action.

Information management

Staff had access to equipment and technology that worked well and supported them to do their work. The systems to collect ward and directorate data did not create extra work for frontline staff. The focus of information governance had been moving towards an integrated electronic patient record and an electronic incident reporting system which were used across the company.

At the last inspection, we found that bank and agency staff were using the same log in to record information onto the electronic care record system. This meant an audit trail of who was making what entry was not possible when a staff name was not added at the end of the entry.

On this inspection, we found that there had been some improvements but this still had not been fully addressed. We sampled daily record entries in patients' notes and saw that out of 23 records made by agency staff, 18 recorded the name but five records had no name added to identify the specific agency member of staff making the written entry in the patients' records. The provider's action plan for this breach, managers said that they would rectify this issue by the end of August 2019 and audit records to make sure the improvements had been embedded.

Engagement

Patients and carers could give feedback about their care through completing surveys.

Since the hospital reopened in May 2019, there had been two staff meeting where staff could listen to leaders but also provide a forum for their views on the running of the hospital. The staff meeting minutes identified that there were discussions on maintenance, the variety of food and activities as well as incidents of unauthorised absence. The meetings consisted of a limited number of discussions about specific, reactive matters that had been identified by staff or needed to be addressed with them. The meetings were not therefore formulated into proper meetings to inform staff and drive improvement through looking at a range of clinical governance items.

Learning, continuous improvement and innovation

Maryfield Court opened in August 2018 but closed temporarily in spring 2019 due to ongoing contract negotiations and a lack of referrals.

There were plans to develop both the psychology and occupational therapy provision at Maryfield Court following recent appointments.

Managers did not have any plans to register with any national accreditation scheme for Maryfield Court such as the Royal College of Psychiatrists'' accreditation for inpatient mental health services working-age adult acute wards scheme, commonly known as AIMS accreditation. The provider had reached aspiring status for autism accreditation which was an autism-specific quality assurance programme run by the National Autistic Society at its other hospital.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the cleanliness of Maryfield Court is improved thorough proper cleaning arrangements and checks.
- The provider must appropriately maintain the building through repainting or repairing walls, repairing or replacing broken furniture, addressing areas of damp within the building and other maintenance work as detailed in the provider's maintenance log.
- The provider must improve security arrangements including ensuring that internal ward doors can appropriately lock and through mitigating risks relating to patients going absent without leave direct from the premises and courtyard areas.
- The provider must improve its checks on the maintenance, cleanliness and security of the premises.
- The provider must improve its safeguarding arrangements to make sure that appropriate action is taken on any abuse or allegation of abuse.
- The provider must make sure that staff carry out dynamic patient risk assessments so risks are reviewed, managed or mitigated following incidents.
- The provider must make sure that each patient has a care plan which addresses each patient's individual needs and is regularly reviewed and updated.
- The provider must make sure that patients are provided with proper opportunities to be involved in collaborating on the development of their own individual care plan and routinely receive a copy of their care plan.
- The provider must improve the quality assurance arrangements so that appropriate health and safety checks are carried out on an ongoing basis including checks for legionella bacteria.
- The provider must improve managers oversight of restraint, and other incidents to make sure that appropriate action is taken when incidents arise.
- The provider must make sure it continues to address the regulatory breaches we found on the last inspection – physical health monitoring on admission and agency nurses clearly signing clinical record entries for accountability purposes.
- The provider must improve the overall quality assurance arrangements so that it routinely checks that its meeting the regulations appropriately and any shortfalls identified from its own audits are actioned within reasonable timescales.

Action the provider SHOULD take to improve

- The provider should ensure that they have sufficiently resourced and dedicated leadership at Maryfield Court so that management responsibility does not fall on one person.
- The provider should ensure they stock remedy medication (Flumazenil) which needs to be available where rapid tranquilisation is use as detailed in the provider's own policy.
- The provider should ensure that agency nurses working at the hospital are clear about the legal status of each patient and records reflect this clarity.
- The provider should consider developing their vision and values which reflect the model of care provided at this service.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 – Person-centred care** **Person-centred care** **Care and treatment did not meet service needs. Staff were not designing care and treatment with a view to service users' preferences and ensuring their needs were met. Staff were not enabling and supporting service users to make, or participate in making, decisions in relation to their care and treatment to the maximum extent possible.** This was because: • Some service users did not have a care plan other than an initial or a 72-hour care plan despite the fact they had been at the hospital for longer periods. • Written care plans were formulaic and were not holistic, recovery-oriented and were not always fully personalised to each individual service users. • Care plan records did not easily identify where the service users were in their progress towards discharge. • Care records did not indicate that service users were involved in the planning of their own care and treatment. • The patients' voice or contribution was not fully evidenced in the written care plan as they were written from the nurse's perspective. • None of the records showed that patients had been given or offered a copy of their care plan.

This section is primarily information for the provider

Requirement notices

The provider was failing to comply with regulation 9 (1) (b) and (3) (b) and (d).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe care and treatment** The provider did not make sure that care and treatment was provided in a safe way and the provider was not ensuring that premises were used in a safe way. This was because: • Staff were not completing or updating service users' risk assessments so they were not dynamic and therefore risks were not managed or mitigated. • Fencing around the premises was easily surmountable. The door of the fence had a significant foothold. There had been a high number of unauthorised absences of service users and the provider had not mitigated the risks to prevent further reoccurrences. The provider was failing to comply with regulation 12 (1) and 12 (2) (d).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Safeguarding service users from abuse and improper treatment** Service users were not protected from abuse. Systems were not operated effectively to prevent abuse of service users and to investigate immediately upon becoming

Requirement notices

aware of any allegation or evidence of abuse. Care and treatment was not provided in a way that ensures that restraint was a proportionate response to the risk of harm posed to the service user or others.

This was because:

- An incident of unexplained bruising of a former female was signed off by the manager without consideration of looking into it further and/or raising as a safeguarding incident.
- Several incident records identified that restraint may have been used but there was no corresponding restraint form to state clearly what type of restraint was used, how long for and by whom and therefore to understand whether the restraint was a proportionate response.
- Managers did not review restraint episodes fully.
- The restraint proforma used at the hospital did not include prone restraint as one of the types of restraint for staff to identify following an incident.

The provider was failing to comply with regulation 13 (1) (2) (3) and (4) (b).

This section is primarily information for the provider

Enforcement actions

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 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 - Safety and Suitability of Premises. **Safety and Suitability of Premises** The provider did not make sure that the premises where care and treatment were delivered were clean, maintained and secure. The provider was also failing to maintain appropriate standards of hygiene. This was because: • There was poor cleanliness in some areas, particularly bathrooms. • The premises were not secure as the door to the ward apartments did not lock fully and patients could easily scale the fence or gate and go absent without leave. • There were significant areas of the premises which required repair or maintenance. • Service users and others were not protected against the risks associated with legionella because of poor systems for checking and the standards did not meet national guidance. The provider was failing to comply with regulation 15 (1) (a) (b) (e) and 15 (2). We have issued a warning notice to Maryfield Court telling them that they must improve in this area by 18 October 2019. We have also placed the hospital into special measures.

This section is primarily information for the provider

Enforcement actions

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 **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 - Good governance** **Good Governance** The provider was failing to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment because they did not have an effective system designed to enable them to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. Therefore, the provider was failing to comply with regulation 17 (1) and 17(2) (b). This was because: • The provider's own systems had failed to maintain appropriate standards of maintenance and cleanliness. • Significant issues about electrical safety and storage of oxygen we found on inspection had not been identified by the provider's own environmental checks. • There were no effective arrangements in place regarding legionella tests and monitoring to ensure that adequate measures were in place to control the risk of exposure to legionella bacteria. • The monitoring of restraint episodes, incidents and safeguarding allegations were not robust. • There was not an overall system for checking whether this service was continually meeting all of the regulations required whilst they were registered with us. • The audits were limited in scope and failed to identify all of the issues we found on inspection. We have issued a warning notice to St Mary's Hospital telling them that they must improve in this area by 30 August 2019. We have also placed the hospital into special measures.