John Munroe Group Limited

Edith Shaw Hospital

Inspection report

Hugo Street
Leek
ST13 5PE
Tel: 01538384082
www.johnmunroehospital.co.uk

Date of inspection visit: 13 January 2021
Date of publication: 27/04/2021

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Edith Shaw Hospital is part of the John Munroe Group and is an independent mental health hospital that provides care, treatment and rehabilitation for up to 14 females, aged 18 or over, with long-term mental health needs. John Munroe Hospital is also part of the John Munroe Group and is located nearby in Rudyard, both hospitals share the same registered manager.

We undertook this unannounced focused inspection based on concerning information received about poor infection prevention and control practice (IPC) and the impact on patient and staff safety. We received several whistleblowing concerns and were informed in December 2020 that the provider had experienced a significant outbreak of COVID-19. In addition, we received death notifications which were all listed as COVID-19-related deaths. In response, a multi-agency improvement plan was implemented at the end of December 2020 to support the provider and gain assurance that actions were in place to mitigate risks to patients and staff. This involved the Care Quality Commission, Public Health England, NHS Staffordshire and Stoke-on-Trent Clinical Commissioning Groups and Health and Safety Executive.

We did not look at all key lines of enquiry during this inspection. However, the information we gathered and the significance of the concerns and clear impact on patients provided enough information to make a judgement about the quality of care and to re-rate the provider.

Following the inspection, we served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider that we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within four days that described how it was addressing the IPC concerns. Their response provided enough assurance that they had acted to address immediate concerns and so we did not take forward urgent enforcement action.

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

- The provider did not ensure all wards were clean, well maintained and fit for purpose. Audits and checks were not enough to provide assurance staff were following good practice to prevent the spread of infection between healthcare workers and patients.
- Safeguarding alerts were not always made as required and the service did not always work well with other agencies.
- The service did not always manage patient safety incidents well. Staff told us they were not always supported to report all incidents appropriately and felt managers did not investigate all incidents. Lessons learned were not always shared effectively with the whole team. When things went wrong, the provider did not always apologise and give patients and their family honest information and suitable support.
- Staff did not always have easy access to clinical information, and it was not easy for them to maintain high quality clinical records, whether paper-based or electronic. Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect. Not all staff had access to the electronic systems which meant they were heavily reliant on the paper records being up to date. Not all staff knew where to find risk assessments or care plans.
- Risk assessments were not always personalised, completed to a good quality or appropriate. We saw examples of risk increasing after control measures were put in place. Risk scoring was inconsistent; the outcome of the risk assessments was classed as being higher than that indicated by the scoring.

Summary of findings

- Staff told us that managers were not always visible, and some were not approachable. Staff gave examples of feeling unsupported and demoralised. Staff suggestions for improvement in patient care were not always acted on. In addition, there were examples of staff being dismissed from their role by managers when raising concerns. Staff told us they felt a blame culture had developed that meant they were reluctant to speak with managers.
- The provider did not always operate effective governance processes throughout the service and with partner organisations. Managers were unable to provide assurance about the safety of the service. Infection prevention and control audits were not always completed, and it was unclear if actions arising from audits had been completed. Investigations including root cause analysis were not always completed to a good standard, there was a lack of consistency and learning from investigations was not always included.
- Teams did not always have access to the information they needed to provide safe and effective care or use that information to good effect. Not all staff had access to the electronic systems which meant they were heavily reliant on the paper records being up to date. Not all staff knew where to find risk assessments or care plans.

However:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The provider was working with the multi-agency review team to address concerns raised in relation to IPC. However, it was too soon to gain assurance that those changes were fully imbedded and sustained.
- At the time of inspection, there was one hospital manager responsible for both John Munroe Hospital and Edith Shaw Hospital. After the inspection, the provider shared plans to reorganise their management structure to ensure each ward had their own manager.
- There had been an improvement in the quality of investigation report templates and reporting into patient complaints. Patients knew how to complain or raise concerns.

As this service has been rated inadequate it will be placed 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inadequate 	We rated this service as inadequate for safe and well-led. We did not inspect the effective, caring or responsive domains, as such their rating of good remains. . Our concerns related to the lack of good governance arrangements, poor infection prevention and control practices, a lack of therapeutic input to support rehabilitation and a culture whereby staff were not supported to speak up.

Summary of findings

Contents

Summary of this inspection

Background to Edith Shaw Hospital

Edith Shaw Hospital is a 14 bedded, female only, community based locked unit. The hospital provides mental health rehabilitation services for women with complex mental health needs.

Edith Shaw is one of two hospitals run by the John Munroe Group Limited. The John Munroe Hospital is located nearby and both hospitals shared the same registered manager. Admissions are taken for women over 55 years of age. Patients may be informal or detained under the Mental Health Act 1983. The hospital is a locked rehabilitation unit with secure perimeter fencing. The hospital contains two lounge areas and all patients' bedrooms have ensuite bathroom facilities.

Edith Shaw Hospital is registered to provide the following regulated activities:

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

The service was most recently inspected in July 2018 and rated good overall; good for safe, effective, caring and responsive, requires improvement for well-led. Following the inspection, we told the provider it must make the following actions to improve:

- The provider must ensure that they have communication systems in place to inform staff of the results of reviews about the quality and safety of the service. Regulation 17

What people who use the service say

We spoke to two carers. They fed back that whilst the patients felt safe, they were not happy with the care and information being shared. They felt they had to constantly ask for information rather than it being freely given. In addition, they felt that their loved one's independence and health were declining rather than improving. There was no garden at Edith Shaw Hospital, there was a sectioned off part of the car park with planters, and there were concerns raised by staff, family members and/or carers that patients did not have enough access to the outdoors and exercise. Staff described outdoor exercise as a walk around the block or to the local shop. Families told us that any concerns or complaints made to Edith Shaw Hospital were not responded to with empathy. We received feedback from four clinical commissioning groups and two care coordinators who gave positive feedback that their patients were well cared for.

How we carried out this inspection

We completed this unannounced focused inspection based on concerning information received about poor infection prevention and control practice and the impact on patient and staff safety. We focused on specific areas of the safe and well-led key questions.

Before the inspection visit, we reviewed information we held about the location and asked a range of other organisations for information. During the inspection visit, the inspection team:

- spoke with the registered manager and interim clinical nurse manager;
- spoke with or had feedback from 20 other staff members; including nurses, occupational therapists, consultant psychiatrists and care support workers;

Summary of this inspection

- spoke with the local independent mental health advocate team and safeguarding teams;
- looked at four care and treatment records of patients and;
- requested feedback from 21 clinical commissioning groups and received responses from four;
- requested feedback from 21 clinical care coordinators and received responses from two;
- looked at a range of policies, procedures and other documents relating to the running of the provider.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

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

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with 9 legal requirements. This action related to both long stay rehabilitation mental health wards for working age adults and wards for older people with mental health problems services.

- The provider must ensure that the care and treatment of patients meets their needs and reflects their preferences by enabling and supporting patients and their carers to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible. Regulation 9(1)(3).
- The provider must ensure patients have access to appropriate and adequate therapeutic intervention in line with National Institute of Care and Excellence guidelines. Regulation 9(1)(3).
- The provider must ensure any complaint received is investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. Regulation 16(1).
- The provider must ensure that they have a clear process by which staff can raise concerns, including verbal concerns and incidents, with agreed managerial responsibilities, and this should be implemented consistently. Regulation 16(2).
- The provider must ensure systems and processes are established and operated effectively to prevent abuse or investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13(1)(2)(3).
- The provider must ensure it has effective governance systems and processes which must be established and operated effectively. These should enable the provider to assess, monitor and improve the quality and safety of their services. Regulation 17(1)(2).
- The provider must ensure that care and treatment is provided in a safe way to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Doing all that is reasonably practicable to mitigate any such risks. Regulation 12(2).
- The provider must ensure all premises and equipment is clean and suitable for the purpose for which they are being used. Regulation 15(1)(2).
- The provider must ensure they promote a culture that encourages candour, openness and honesty at all levels. Regulation 20(1)(3).

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Summary of this inspection

- The provider should ensure that support workers understand the work of the multidisciplinary team and what they do when not on wards to ensure patients receive specific treatment. Regulation 12.
- The provider should ensure they assess the potential risks of a closed culture and address any identified actions as a result to drive improvement. Regulation 17.
- The provider should ensure their Freedom to Speak up Guardian has received the relevant training and is sighted on staff concerns received within the service via other avenues. Regulation 17.
- The provider should ensure they explore silo working to ensure that there is a cohesive approach to team working that engages all teams, and that supports staff who do not feel they have a voice outside of their peer group. Regulation 17.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Well-led	Inadequate

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

Inadequate

This was a focused inspection responding to specific areas of concern. Our rating of safe went down. We rated it as inadequate because:

- The provider did not provide assurance that all wards were clean, well maintained and fit for purpose. The provider did not complete routine hand hygiene audits, relying instead on spot checks completed as part of the six-monthly infection prevention and control (IPC) audit. This did not provide assurance that staff were following good practice to prevent the spread of infection between healthcare workers and patients. The hand hygiene sinks available for staff to wash their hands did not conform to infection prevention and control guidelines, which made it difficult for staff to adequately wash their hands. The provider did not have any plans in place at the time of inspection to upgrade the hand washing facilities.
- The service completed IPC audits every six months. During the inspection we asked to see the most recent IPC audit for all wards, we were not supplied with audits for Edith Shaw Hospital. In addition, the provider did not increase IPC audits during the COVID-19 outbreak in December 2020 to provide themselves with assurance that the areas within Edith Shaw Hospital were clean and well maintained. The provider did complete IPC audits for all areas in January 2021.
- On inspection we saw the provider had enough personal protection equipment (PPE). However, staff fed back that this had been a recent change since the implementation of the multi-agency review. Staff reported being asked to wear the same face masks for multiple days and being asked to take single-use visors home to clean and re-wear. When staff requested additional PPE, they reported being challenged by managers, who questioned why it was required. There were insufficient clinical waste bins for staff to dispose of face masks and other PPE. This increased the risk of spreading infection. This was raised to the provider who responded by implementing yellow clinical waste bins.
- The service did not always work well with other agencies where safeguarding concerns had been raised. The independent mental health advocacy team were not always made aware when their patients were party to a safeguarding meeting. This meant they could not adequately support the patient. Following the inspection, the independent mental health advocacy team told us communication with the service had improved.
- The service did not manage patient safety incidents well. Staff said they were not always supported to report all incidents appropriately and felt managers did not investigate all incidents. Lessons learned were not always shared effectively with the whole staff team. When things went wrong, we found the provider's systems for duty of candour were not always effective and patients were not adequately supported when they raised concerns. We saw investigations completed without patients having access to their Independent Mental Health Advocate (IMHA). This meant that patients did not have support to ensure they were heard when raising concerns. Following the inspection, the independent mental health advocacy team told us communication with the service had improved.
- The provider's approach to debriefing after incidents was inconsistent. We heard from staff who had received debriefs and found them to be supportive and from other staff who had not. For those staff who had not received a debrief, the support was provided by peers to check they were okay.
- Staff, including managers, did not always have a good understanding of The Duty of Candour. When we reviewed death notifications, we found that Duty of Candour had not been discharged despite it being required to do so in the

circumstances of the deaths. This was fed back to the provider who then completed their duty. However, we were not assured they fully understand the requirement to do so. The Duty of Candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.

- Staff did not always have easy access to clinical information, and it was not easy for them to maintain high quality clinical records, whether paper-based or electronic. Patient records were kept on an electronic database, an online folder structure and within a paper folder. Not all information needed to deliver patient care was available or easily accessible to all relevant staff, including agency staff, when they needed it. The provider told us they had plans to implement a new electronic record system, which all staff would have access to. Following the inspection, the provider shared with us their timeline for implementation.
- At this inspection, staff told us support workers did not have access to the electronic systems and as such relied on the paper folders being kept up to date. The provider kept live care plans and risk assessments on the electronic patient record system, documents that could be added to daily if needed, and printed them when updated to add to the paper folder. However, staff said they did not always have the most recent patient information. This was risk as staff could not always be sure they knew the patients' current risks and care needs. We were given examples of staff not following care plans designed by occupational therapists which then led to patients losing their independence.
- Staff completed risk assessments of every patient on admission and updated it regularly. The risk assessment tool covered risk categories including harm to self, harm to others, vulnerability, physical heath and deterioration in quality of life. We found risk assessment provided detailed descriptions of the patient and their identified risks. Staff developed management interventions for patient risks identified by assessments. However, the quality of risk interventions varied. Not all provided detailed risk interventions personalised to the needs of the patient. For example, a risk management intervention with a frequency recorded only as 'toilet regularly'.
- Support workers told us they were not always able to attend patient meetings or felt empowered to input into them. This included multidisciplinary and care programme approach meetings. This led to a lack of understanding of the clinical judgements being made and a lack of understanding of the roles of the multidisciplinary team. Staff told us they felt clinical decisions were sometimes made without the multidisciplinary team fully understanding the patient risk due to not having representation from support workers. The lack of representation and a culture of not reporting incidents or concerns to leaders meant there was a concern vital information about patient care was not being discussed. Support workers made up a substantial proportion of the workforce and spent the longest time with patients.
- Not all staff, including nurses, knew where to find the patient risk assessment. This meant we were not assured all staff knew the patients' risks and were able to provide safe care.
- The service did not always have enough staff who knew the patients. However, the provider was in the process of recruiting nursing staff at the time of the inspection. The psychology lead had recently resigned from their post. The service required a consultant psychologist to provide supervision and oversight to the assistant psychologists, which meant that they could not be employed whilst the provider was in the process of recruiting additional psychologists. As such the provider was unable to provide psychological therapy to patients. Following the inspection, the provider told us a psychologist had been successfully recruited.

However, we also found:

- The provider was working with the multi-agency review team to address concerns raised in relation to the management of IPC. However, it was too soon to gain assurance those changes were fully embedded and sustained.
- Following the inspection, the provider informed us that they had implemented a new weekly hand hygiene audit.

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Inadequate

This was a focused inspection responding to specific areas of concern. Our rating of well-led went down. We rated it as inadequate because:

- Leaders did not operate effective systems or processes to ensure high quality and safe care. As such they were not always able to assess, monitor or improve the quality and safety of the services provided. There was limited understanding of the importance of culture. There were low levels of staff satisfaction with staff not feeling respected, valued, supported or appreciated. There was poor collaboration and cooperation between teams and there are high levels of conflict.
-
- Staff did not find managers to be visible and approachable. Staff told us they had limited contact with the Hospital Manager and provided examples of some senior managers being rude and unresponsive. Managers could not identify or did not understand the risks and issues described by staff. Staff gave examples of feeling unsupported and demoralised. We often heard staff were dismissed by managers when raising concerns and when suggesting improvement in patient care. Staff told us a blame culture had developed that meant they were reluctant to speak with managers.
- Not all staff felt respected, supported, and valued by managers and peers. They did not always feel able to raise concerns without fear of retribution. We found a notable change in the culture since our last inspection in July 2018. Staff told us morale was low and that there was a culture of bullying, gossip, and malicious complaints. The culture was not one of openness, transparency or candour. When something went wrong people were not always told and did not always receive an apology. Staff gave examples of bullying and harassment by colleagues and managers which were not addressed. When raising concerns, staff told us they did not feel they were treated with respect nor did they feel supported.
- The provider did not have a robust process by which staff could raise concerns, including verbal concerns, with agreed managerial responsibilities. When concerns were raised, staff told us they received little or no feedback and as such felt those concerns were not managed. We were given examples of staff being dismissed after they raised concerns. Managers did not always deal with poor staff performance when needed. Whilst overall, we found individual teams worked well together, we also saw a culture of silo working where staff reported bullying occurred if certain individuals did not get on.
- The provider had recruited a Freedom to Speak up Guardian in November 2020, who was employed to work one day a week. Freedom to Speak Up Guardians support workers to speak up when they feel they are unable to do so by other routes. They ensure people who speak up are thanked, the issues they raise are responded to, and make sure the person speaking up receives feedback on the actions taken. At the time of the inspection the Guardian had not completed the national Freedom to Speak up Guardian training. The provider told us this had been delayed due to the COVID-19 pandemic but did not provide any evidence of how the risks associated with not having access to the training was being managed in the interim. Following the inspection, the provider told us the Guardian had booked the training.
- The provider had employed an independent non-executive board member in September 2020. They commenced their position in November 2020 and had started to explore closed cultures as part of their role. However, not all staff including managers were aware of this and could not give examples of ongoing work to combat closed cultures. (A closed culture is a poor culture which has an increased risk of harm, including abuse and human rights breaches. This can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones. Closed cultures are more likely to develop in services where people are removed from their communities, where people stay for months or years at a time, where there is weak managership and where staff often lack the right skills,

training or experience to support people. They are also more likely to develop where there's a lack of positive and open engagement between staff and with people using services and their families. In these services, people are often not able to speak up for themselves. This could be through lack of communication skills, lack of support to speak up or abuse of their rights to).

- The provider did not always operate effective governance processes throughout the service and with partner organisations. Managers did not provide assurance about the safety of the service. Infection prevention and control audits were not always robust or completed. There was limited management oversight of what audits were in place. For example, we requested the hand hygiene audits from senior managers and were informed there were none. We were told managers relied on nursing staff to ensure staff followed hand hygiene procedures without a formal process being in place. When we asked if staff received refresher training or were shown examples of good practice, we were informed staff were shown what to do on their training and it was their responsibility to ensure it was correct. As such there was a lack of accountability within the management team as to ensuring good practice and standards of care amongst their staff groups.
- The provider completed investigations including root cause analysis for incidents and complaints. However, the quality of reporting was mixed. We reviewed the root cause analysis for recent COVID-19 deaths and found them to be of poor quality. There was no acknowledgement of the poor infection prevention and control (IPC) practices highlighted throughout the multi-agency review. In contrary, the reports stated there were no breaches of PPE or IPC despite there being no audits or oversight to support those claims. The reports lacked personalisation and detail and did not include all relevant learning. Patients who raised complaints or were interviewed as part of an incident were not supported to access independent mental health advocates. Following the inspection, the independent mental health advocacy team told us communication with the service had improved.
- The patient record systems were not clear, with information being saved in various systems and folders. We found various aspects of patient information kept in a paper folder, within an electronic records system and within an online folder structure. Each patient had an online folder created under their name, but we found the folder structures and usage to be inconsistent. There was a lack of management oversight of the quality of care plans and risk assessments. Following the inspection, the provider shared with us their timeline for implementation of a new record system.
- Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect. Not all staff had access to the electronic systems which meant they were heavily reliant on the paper records being up to date. Support workers who spent the largest amount of time with patients were unable to contribute to care notes or log incidents. The paper records whilst indexed were laid out as such that the most up to date information was found toward the back of the record. These records could be quite large, and this meant staff would need to navigate several sections to find information such as risk assessments and care plans.
- Staff reported that the electronic system was not updated consistently and was difficult to navigate. For example, it was not always easy to find multidisciplinary team meeting notes, meetings where clinical decisions were made, and staff had to rely on key word searches to find information. The provider told us they were in the process of procuring a new record system. However, there were no plans in place at the time of the inspection as to when this would be implemented. Nor was this communicated to staff. Following the inspection, the provider shared with us their timeline for implementation.

However, we also found:

- At the time of inspection, there was one hospital manager responsible for both John Munroe Hospital and Edith Shaw Hospital. Following the inspection, the provider shared plans to reorganise their management structure to ensure that Edith Shaw would have a separate Registered Manager.
- The provider was in the process of sourcing a new care management system to centralise their patient records. In addition, there was an intention to provide staff with work email addresses.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

- One Clinical Commissioning Group contacted us to inform us of their positive experiences of the hospital. Including the kind, caring and compassionate nature of the staff team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider must ensure any complaint received is investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. Regulation 16(1). The provider must ensure that they have a clear process by which staff can raise concerns, including verbal concerns and incidents, with agreed managerial responsibilities, and this should be implemented consistently. Regulation 16(2).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure that the care and treatment of patients meets their needs and reflects their preferences by enabling and supporting patients and their carers to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible. Regulation 9(1)(3). The provider must ensure patients have access to appropriate and adequate therapeutic intervention in line with National Institute of Care and Excellence guidelines. Regulation 9(1)(3).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider must ensure systems and processes are established and operated effectively to prevent abuse or investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13(1)(2)(3).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **The provider must ensure they promote a culture that encourages candour, openness and honesty at all levels. Regulation 20(1)(3).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider must ensure all premises and equipment is clean and suitable for the purpose for which they are being used. Regulation 15(1)(2).**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Following the inspection, a warning notice was issued to the provider which told the provider areas which must be improved. In particular:** • There were not effective governance systems and processes that were established or operating effectively. • We found a lack of focus on the clinical leadership and governance systems. • We found a lack of managerial oversight of the numbers of patients and staff affected by COVID-19. • We found a lack of effective infection prevention and control systems. • There was limited management oversight of what audits were in place and whether actions arising from previous audits had been completed. • We reviewed the root cause analysis for recent COVID-19 related patient deaths and found them to be of poor quality. • We reviewed 10 investigations including root cause analysis for incidents and complaints. However, the quality of reporting was mixed. • We found the patient record systems were not clear, with information being saved in various systems and folders. • Not all staff had access to the electronic systems which meant they were heavily reliant on the paper records being up to date.