Mundesley Hospital

Quality Report

Cook's Hill,
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Mundesley
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Date of inspection visit: 12-13 January 2017
Date of publication: 13/03/2017

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

Overall summary

CQC carried out a focussed unannounced inspection of Mundesley hospital on 12 to 13 January 2017. This inspection concentrated on reviewing progress against a warning notice and requirements notices following a comprehensive inspection of the service in September 2016.

At this inspection we found that:

- The risk management process remained incomplete. Staff did not identify all risks; therefore, not all risks were addressed in the care plans.
- Staff did not routinely carry out assessments on admission and this meant that staff did not identify all the physical health needs of patients.
- Where a patients physical or mental health needs changed there was limited evidence of review.
- Where staff identified the need to monitor a patient's food or fluid intake, there was a lack of review of the information or subsequent action taken.
- There was limited evidence of individual risk assessment taking place prior to a patient going on Section 17 leave.
- Rapid tranquilisation forms were in place but one was missing. Staff had not noticed this when using the provider's own internal audit.
- Staff did not always record physical health observations following rapid tranquilisation. A patient's physical health can deteriorate following this treatment and it is essential to monitor patients' physical observations to detect any deterioration in health.
- We identified that contemporaneous records were not accurate, and did not evidence patients' progress. Information lacked detail and at times was repetitive.
- It was not clear from daily entries if the patient was detained or informal. There was no evidence of how staff implemented care plan goals. Staff did not record decisions regarding a patient being on enhanced observations nor was there a daily review of enhanced observations by the doctor. Enhanced observations are designed to increase support to the patient in acute times of distress where staff have assessed that the patient is at increased risk of harm to self or others.
- There was no audit in place to monitor the quality of entries in patient records. However, the manager did evidence plans for staff to receive training regarding record keeping.
- Managers were developing audits of clinical systems. However, we identified several issues that had not been highlighted through audit.

However:

- We saw an improved system in place for reporting of incidents, restraint and rapid tranquilisation. Managers had begun to deliver training to staff on how and what to report as an incident. We saw evidence of improved reporting of incidents. The provider had introduced a system for capturing information from adverse events and had begun to use the information to learn lessons.
- 67% of staff had completed basic life support training that included the use of the defibrillator (AED). The provider had also identified intermediate life support training and had a plan for implementation.
- Gaps in signatures on medication charts had greatly reduced. We identified three gaps in administering creams, however the pharmacy had identified the errors, and the hospital had investigated.
- Managers had updated the hospital environmental risk assessment to include the identification and management of potential ligature risks. Further work was planned to continue to improve the safety of the environment.
- We identified a significant improvement in mandatory training figures. 84% of staff were compliant with their mandatory training.
- The provider had delivered training in the Mental Health Act and Mental Capacity Act. 72% of staff had received training in the Mental Health Act and 87% had completed training in the Mental Capacity Act. This was an improvement and further sessions were booked.
- Managers had updated the risk register, which now reflected clinical as well as business risks. Managers provided information on further planned improvements to procedures to manage organisational risk.

Summary of findings

- During this inspection, we found that managers had implemented a system to ensure that staff reported notifiable promptly.

CQC will continue monitor the service whilst in special measures and a further comprehensive inspection will take place to assess all areas identified at the previous comprehensive inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units		Inspected but not rated.

Summary of findings

Contents

Mundesley Hospital

Services we looked at
Acute wards for adults of working age and psychiatric intensive care units

Summary of this inspection

Background to Mundesley Hospital

Mundesley Hospital was registered with the Care Quality Commission in December 2015 and patients were first admitted in February 2016. It is registered to carry out the following regulated activities:

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

The Mundesley Hospital is a private mental health care facility in the North Norfolk countryside. The hospital has 27 beds for adults who require assessment and treatment in an inpatient setting. Patients are either informal or detained under the Mental Health Act (1983).

The hospital provides acute in-patient care for patients requiring urgent and immediate treatment for their mental health condition.

There are six wards located over two floors.

On the ground floor, there are two adjoining in-patient suites which the provider called wards, Middleton and Chrome. Both can accommodate up to six patients each and are designated male in-patient suites.

On the first floor, there are four in-patient suites. Thirtle, Stannard, Vincent and Bright wards can accommodate four patients each. Thirtle and Stannard are designated female in-patient suites. Vincent and Bright are for either male or female patients.

A registered manager was in place at the location. The registered manager, Sue Howlett, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

The hospital was first inspected in September 2016 and found to be rated Inadequate overall. Following this the hospital was placed into Special Measures by the Chief Inspector Of Hospitals in December 2016.

This was an unannounced focussed inspection to establish if Mundesley Hospital achieved compliance against the Warning Notice and Requirement Notices made following the previous inspection.

Our inspection team

Team leader: Jane Crolley, Inspector

The team that inspected the service comprised two CQC inspectors, a mental health act reviewer and two inspection managers.

Why we carried out this inspection

This unannounced, focussed inspection was part of a programme to monitor performance. The Care Quality Commission placed Mundesley Hospital in Special Measures in December 2016, following a comprehensive inspection completed in September 2016.

We also undertook this inspection to confirm whether Mundesley Hospital had achieved compliance with a Warning Notice issued in October 2016.

Ratings are not given for this type of inspection.

When we inspected the provider in September 2016, we rated the service as inadequate overall. We rated safe and well led as inadequate, effective as requires improvement and caring and responsive as good. We identified a number of breaches and issued a warning notice against the Regulations as follows:

Regulation 12 (1) and (2) (a),(b), (c), (d), (f), (g) Safe Care and Treatment Health and Social Care Act 2008 (Regulated Activities)

Summary of this inspection

- Patient care plans were not completed fully, lacked detail, and were not based upon individual risk assessment.
- Escorting of patients was not based on a clinical assessment of individual risk
- Some incidents were not reported on the provider's incident reporting system or updated on individual risk assessments and care plans.
- Immediate life support training including use of a defibrillator was not provided for staff.
- The recording of rapid tranquillisation and restraint was incomplete and nurses did not consistently monitor the physical health of patients who had received this.
- Nursing staff did not always record when medications had been administered, or why medications had been omitted. Some medications had run out of stock.

Regulation 17 (2) (a –d) Good Governance of The Health and Social Care Act 2008 (Regulated Activities)

- Incident forms were not always being completed by staff as expected, and when they were – many were incomplete and not all were signed off by senior managers.
- Staff were not recording incidents of restraint consistently.
- There was no formal structure for staff to learn lessons from incidents.
- There was not always an accurate, complete and contemporaneous record of care and treatment.
- Where audits had been undertaken there was not always evidence of action to address the issues found.
- The hospital's environmental ligature risk assessments had not been reviewed since the hospital began admitting patients.
- The risk register did not reflect all risks found at the hospital.

We told the provider they must be compliant with the warning notice by 23 December 2016.

During the inspection in September 2016 we also issued requirement notices against the Regulations as follows:

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Staff were not up to date with their mandatory training and there was no provider plan to address this.

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The provider did not comply with all the policy and practice to meet the requirements set out in the Mental Health Act code of practice.

Regulation 18 CQC (Registration) Regulations 2009 Notification of other Incidents.

- The hospital had not reported incidents to the Care Quality Commission in a timely manner. This meant that the Commission had not been informed of some notifiable incidents as required.

Prior to this inspection the hospital managers provided the CQC with an action plan about how they would achieve compliance with the Regulations. The CQC made an unannounced inspection on the 12 to 13 January 2017 for assurance that the improvements stated by the provider had been made. This report contains the findings of that inspection.

How we carried out this inspection

To fully understand the progress made by the service we concentrated our inspection on the following domains:

- Is it Safe?
- Is it Effective?
- Is it Well Led?

Before the inspection visit, we reviewed the warning notice and the action plan provided by the provider on how they planned to achieve compliance.

During the inspection visit the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 12 patients who were using the service;
- spoke with senior management, the registered manager and managers or acting managers for each of the wards;

Summary of this inspection

- spoke with 20 other staff members; including doctors, nurses and healthcare assistants.
- looked at 10 care and treatment records of patients:
- carried out a specific check of the medication management;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- examined minutes and other documents relating to incidents and clinical governance inside the hospital.

What people who use the service say

We spoke with 12 patients during this inspection.

One female patient said that there were days when the staff team were all male or were agency.

Two patients said that they had to make several requests before staff provided answers to their queries, and at times, it could be days before staff provided feedback.

Patients said activities external from the ward were limited to the morning due to staff breaks taking place in the afternoon.

Patients reported knowing how to complain and felt comfortable raising concerns. Patients reported staff treated them with dignity and respect.

We spoke with patients, as part of the inspection process but as this was an unannounced inspection, the emphasis was to review the warning notice for compliance.

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?

The hospital had not addressed all actions identified in the Warning Notice.

- The risk management process remained incomplete. Staff did not identify all patient risks; therefore, not all risks were addressed in the care plans. We saw insufficient evidence of staff reviewing care where staff had identified risks.
- We found care plans and risk management plans lacked detail and did not address all patients' needs. For instance, staff identified areas of risk regarding mobility, fluid intake and choking but the plans to manage those risks was not available or lacked detail. Where staff identified the need to monitor a patient's food or fluid intake, there was a lack of review of the information or subsequent action taken.
- Staff did not routinely carry out falls assessments, even when staff had identified a risk.
- There was a lack of formal risk assessment prior to the patient going on Section 17 leave. There was no crisis or contingency plan describing what staff should do if they encountered a problem whilst the patient was on leave.
- Rapid tranquilisation forms were in place but one was missing. The manager had not identified this via the provider's own internal audit.
- Staff did not always record physical health observations following rapid tranquilisation. A patient's physical health can deteriorate following this treatment and it is essential to monitor patients' physical observations to detect any deterioration in health.
- There was no management plan on how to maintain the sharpness of ligature cutters. Staff were unclear of procedures.

However:

- Storage and administration of medication had improved. Gaps in signatures on medication charts had greatly reduced. We identified three gaps in administering creams, however the pharmacy had identified the errors, and the hospital had investigated.
- We did not see use of seclusion.
- 67% of staff had completed basic life support training that included the use of the defibrillator (AED). The provider had also identified intermediate life support training and had a plan for implementation.

Summary of this inspection

- There was a significant improvement in mandatory training figures. 84% of staff were compliant with their mandatory training.Figures for safeguarding adult training completion were 94% and 87% for children's safeguarding training.
- Senior managers had reported incidents to the CQC. We saw an improved system in place for reporting of incidents, restraint and rapid tranquilisation. Managers had begun to deliver training to staff on how and what to report as an incident. We saw evidence of improved reporting of incidents. The provider had introduced a system for capturing information from adverse events and had begun to use the information to learn lessons.

Managers had updated the hospital environmental risk assessment to include the identification and management of potential ligature risks. Further work was planned to continue to improve the safety of the environment.

Are services effective?

The hospital had not addressed all actions identified in the warning notice.

- Staff had not fully completed nursing physical health assessments in all ten of the care records reviewed.
- Staff did not routinely carry out assessments on admission and this meant that staff did not identify all the physical health needs of patients.
- Where a patients physical or mental health needs changed there was limited evidence of review.
- There was no evidence of consideration of referral to services such as physiotherapy or speech and language therapy.
- None of the records we reviewed consistently demonstrated accurate and complete records of care. Descriptions of incidents lacked detail. Staff did not clearly record outcomes from interventions.
- Patient records were confusing. Staff recorded some incidents twice with slightly different information relayed each time. It was not always clear if the entry was for the same incident or not.
- Handwriting was not always legible so difficult to decipher.
- It was not clear from daily entries in the care notes if the patient was detained or informal. Staff did not record decisions regarding a patient being on enhanced observations nor was there a daily review of enhanced observations as expected in their own policy of Safe and Supportive Observations.

However:

Summary of this inspection

Staff attendance at training for Mental Health Act and Mental Capacity Act had improved.

Are services caring?

This was a focussed unannounced inspection and we did not inspect this domain.

Are services responsive?

This was a focussed unannounced inspection and we did not inspect this domain.

Are services well-led?

The hospital had not addressed all actions identified on the warning notice.

- There was a lack of evidence of effective oversight and review of contemporaneous notes by senior staff. The clinical entries lacked detail, were not always legible due to poor handwriting and did not reflect patient progress. Managers had not highlighted this concern through audit systems.
- Although we saw incidents in the contemporaneous notes that staff had not recorded on the incident report system, we recognised there was some improvement since the last inspection. Further improvement was required.
- There remained some areas of poor practice, identified throughout this report, which staff had not highlighted through internal audit and management systems. Managers told us they had plans to improve in these areas but this was yet to lead to improvement.
- Closed circuit television cameras were in operation in the hospital however, there were no signs advising patients it was in place.

However:

- Managers had updated the hospital environmental risk assessment to include the identification and management of potential ligature risks. Further work was planned to continue to improve the safety of the environment. There were two risks not identified, we alerted the Director of Nursing who took immediate action to rectify this.
- During this inspection, we saw improvement in staff reporting incidents to the CQC.We reviewed the incident reports and all notifiable incidents had been reported to the CQC as well as being reported through the hospitals own system.
- Mandatory training compliance had improved and the compliance rate was 84% against a rate of 63% at the last inspection.

Summary of this inspection

- Managers had updated the risk register, which now reflected clinical as well as business risks. Senior managers had strengthened governance arrangements to include clearer terms of reference and set agendas for meetings. The board was now sighted on key organisational risks. Managers provided information on further planned improvements to procedures to manage organisational risk.

Detailed findings from this inspection

Mental Health Act responsibilities

We identified at the last inspection poor compliance with training with only 46% of staff receiving training in the Mental Health Act (MHA).

- During this focussed inspection, there was an improvement and training compliance was 72% for the MHA.

At our last inspection, we had identified that the provider did not comply with all policy and practice to meet the requirements set out in the Mental Health Act code of practice.

- During this inspection, we found continued concerns about the application of the MHA as set out under the effective domain.

Mental Capacity Act and Deprivation of Liberty Safeguards

We identified at the last inspection poor compliance with training with only 33% of staff receiving training in the Mental Capacity Act (MCA).

During this focussed inspection, there was a significant improvement and compliance was 87% for MCA Training.

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

At our last inspection in September 2016, we identified that there were inadequate measures to ensure that the environment was safe. Specifically, staff had not reviewed the environmental ligature risk assessment since the hospital had opened to patients.

- During this inspection, we saw an up to date ligature assessment. There were some risks not reflected and we alerted the Director of Nursing who took immediate action to rectify this. A ligature is a fixed fitting on which someone could tie an item to it and use for the purpose of self-strangulation. Further work was planned, to continue to improve the safety of the environment.
- There was no management plan on how to maintain the sharpness of ligature cutters. Staff were unclear of procedures. This posed a risk of the cutter not being sharp enough to be effective in an event where a ligature needed removing urgently.

Safe staffing

At our last inspection in September 2016, we identified that staff were not up to date with their mandatory training and there was no provider plan to address this.

At this inspection, we found that mandatory training compliance was 84%, an improvement form the last inspection where compliance was just 63%.

At our last inspection, we identified that basic life support training (BLS) was delivered without training in the use of the automated external defibrillator (AED). 63% of staff had received the BLS training. None of the staff received training on intermediate life support (ILS) which is a more advanced course for preserving life.

- During this inspection, we saw BLS training had taken place to include the AED and 67% of staff had completed this training. Further training was required to ensure all staff had the appropriate skills. The provider had identified an external trainer and sessions were booked for immediate life support (ILS) training. At the time of the inspection, seven staff had received ILS training.
- Managers did not identify on the rota if there was a staff trained in ILS on each shift. This meant it was unclear if there were the correctly skilled staff on duty. We raised this with the provider.

Assessing and Managing Risk to Patients

At our last inspection in September 2016, we identified that care plans and risk assessments did not address all the needs and risks in relation to the patients.

- During this inspection, we continued to find care plans and risk assessments were not detailed and did not address all patients' needs. Staff had not reflected all identified risks in the risk assessments.
- For instance, we saw a patient was at risk of choking. We were unable to find any evidence of the consideration of a speech and language therapist referral for a swallowing assessment. The arrangements in place in the care plan did not consider all the risks. We raised this with the provider during inspection and the provider planned a full review of the patients care and treatment.
- Staff had identified a concern regarding a patient's fluid intake. However, the recording of the patients' fluid intake was incomplete and there was no evidence of review of the information gathered. We saw that the

patient had drunk between 500mls and 700 mls of fluid each day for several days. NHS recommended guidance is around 1.2 litres daily. There had not been any action taken. The exact measure of intake was not always clear, for instance, on occasion staff would record a bowl of cereal with milk. Staff did not measure the volume of milk. There was no evidence of attempts to encourage extra fluids and there was no goal in the patients care plan for the patient and staff to follow. We raised this concern with the provider during inspection

- We saw staff pushing a patient forward in a wheelchair, both within the ward and in the garden area, with staff having to stop frequently and ask the patient to lift their foot. This practice placed the patient as significant risk of injury due to the high risk of the foot being trapped. Potentially the patient could suffer a broken ankle or be dragged from the chair. We raised this with the provider and footplates were found and put onto the wheelchair. There was no guidance for staff on how to use the wheelchair if the footplates needed removing for safety reasons. We brought this to the attention of the provider who made changes to the care plan immediately.
- One patients contemporaneous notes highlighted a fall due to mobility issues. There was no falls screening or assessment in place before this incident and no action taken afterwards to complete one. There was no management plan to guide staff in how to manage this risk. There was no evidence of medical review following the fall.
- It had been documented that one patient had significant weight loss. We could not see any evidence of medical review of the weight loss. We raised this with the provider for their intervention.

At our last inspection, we noted that the hospital was not following rapid tranquilisation monitoring guidance.

- During this inspection we saw improvements in the monitoring and recording of rapid tranquilisation administration however further improvements needed to be made (as described in the following points) to ensure compliance.
- Staff were not consistently using the NEWS (National Early Warning Scale) charts to record physical observations following rapid tranquilisation. We saw evidence that managers had requested staff to use them. However, managers had no mechanism in place that informed them that it was not happening. We checked one patient record regarding rapid tranquilisation. The patient had intramuscular injection for acute disturbance on three occasions. Monitoring forms were in place on two occasions, one was missing and had not been picked up by the hospitals own internal audit system.

At our last inspection, we noted significant gaps in recording of administration of medication and gaps where staff could not administer medication due to being out of stock.

- During this inspection, we saw an improvement in the recording of administration of medication. We observed three gaps (for creams).The pharmacist had already identified this and brought the errors to the attention of managers.
- There were two occasions when staff did not administer medication due to it being out of stock. This was an improvement from the last inspection, however, required further improvement.
- We saw liquid medication open which did not have the date when staff opened it. Once staff open a bottle of medicine the 'use by' date changes from when it is sealed. We brought this to the attention of the nurse who disposed of it immediately.
- Staff were not using the index of the controlled drug register. This made it more difficult for staff to find the correct page for use. Correct use of the index identifies exactly where a member of staff can find the correct page to record medication. The controlled drug register is a register for ensuring the safe management of medications that are legally identified as needing extra control measures due to their risk of misuse.

At our last inspection we had identified a patient had been secluded which was against the providers own policy.

- During this inspection, we did not see incidents of seclusion, however contemporaneous notes did not always demonstrate clear record of care and treatment. For instance, we saw that staff redirected patients to their room following an incident of aggression. It was unclear from records if the patient was able to refuse this option or leave their room at will. In one patients care plan, staff recorded that a patient was to be taken to their room but the plan lacked detail on whether this was intended as seclusion or redirection.

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

- We reviewed one patient who was in long-term segregation. The historical and current risks in the risk assessment were indistinguishable making it impossible to establish a timeline of incidents and to determine what had happened since the previous review.
- The care plan identified a daily review was required by the psychiatrist. Records showed reviews took place on five occasions in December 2016.
- There was a lack of formal risk assessment prior to the patient going on Section 17 leave. There was no crisis or contingency plan describing what staff should do if they encountered a problem whilst the patient was on leave.

At our last inspection we identified that individual patient freedom was restricted for reasons other

than an assessment of individual risk. Staff escorted patients throughout the building due to the layout of the building and the identified environmental risks as opposed to individual risk

assessment.

At this inspection, we found informal patients were able to move more freely. However, due to the design of the building it was impossible to move completely freely around the building.

Reporting incidents and learning from when things go wrong

At our last inspection, we had identified that there was no formal structure for staff to learn lessons from incidents.

- Senior managers had reported incidents to the CQC. We saw an improved system in place for reporting of incidents, restraint and rapid tranquilisation. Managers had begun to deliver training to staff on how and what to report as an incident. We saw evidence of improved reporting of incidents.
- Managers had introduced a system to ensure incidents were reviewed and staff learned lessons. We saw evidence of discussion within team meetings and governance meetings. We identified there was a lack of detail in sharing specific actions to improve practice following incidents. This was in its infancy and requires time to embed in practice.
- We saw incidents in the contemporaneous notes that staff had not recorded on the incident report system. Whilst we recognised improvements were made, further improvements were required.

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

(for example, treatment is effective)

Assessment of needs and planning of care

At our last inspection, we identified that assessment of need was not routinely completed.

During this inspection, we found the same as demonstrated in the following points.

- The nursing assessment, that the provider had identified staff must complete on admission, was either incomplete or not completed in all ten of the notes reviewed.
- Staff did not complete the Waterlow assessment in all ten patient notes reviewed. (This assesses skin condition and identifies if there is a risk to skin that may need intervention or monitoring).
- The Malnutrition Universal Screening Tool, better known as the MUST assessment (identifies nutritional risks) and VTE screening which assesses if a patient is at risk of developing venous thromboembolism, (a clot in the vein) were not completed.
- Staff did not complete body maps, even where staff had identified a risk.
- There was no moving and handling assessment in the clinical records for a patient with mobility difficulties.
- The hospital employed an occupational therapist (OT). However, we identified that 9 out of 10 care plans did not include therapeutic treatment goals such as groups or tailored sessions, or an indication of OT involvement in multidisciplinary discussions.
- We saw evidence in one record out of ten records reviewed, of OT involvement. We saw the OT had completed a risk assessment and included practice guidelines from the College of Occupational Therapists. The OT regularly recorded discussions with this patient, and we saw attendance at their multidisciplinary meetings.
- Where patients had complex physical health needs, with potential need for equipment to aid completion of tasks, we did not find evidence of OT assessment in patient's records.

- There was a request for staff to monitor a patient's weight due to physical health concerns. There was no weight chart and we could not find evidence of attempts by staff to weigh the patient.
- In one patient record, staff had recorded that the patient was not compliant with assessments. There was no further evidence of attempts to assess the patient and no mental capacity assessment in place. There was no evidence of a best interest meeting to discuss the patient's physical health. We raised this with the provider who agreed to review the patients care.
- There was no evidence of consideration of referral to services such as physiotherapy or speech and language therapy. We did see evidence of a dietician referral and outcome letter. However, not all the recommendations from the outcome letter where addressed.
- Contemporaneous clinical entries lacked detail and did not demonstrate patient progress. Descriptions of incidents lacked detail. Staff did not clearly record outcomes from interventions.
- Patient records were confusing. Staff recorded some incidents twice with slightly different information relayed each time. It was not always clear if the entry was for the same incident or not.
- It was not clear from daily entries in the care notes if the patient was detained or informal. Staff did not record decisions regarding a patient being on enhanced observations nor was there a daily review of enhanced observations as expected in their own policy of Safe and Supportive Observations.
- Handwriting was not always legible so difficult to decipher.

Adherence to the MHA and the MHA code of Practice

At our last inspection, we identified that only 46% of staff had received training on the Mental Health Act (1983).

- During this inspection, we identified that training attendance had improved with 72% of staffing having completed MHA training. Managers assured us that further training was planned to improve these figures further.

At our last inspection, we had identified that the provider did not comply with all policy and practice to meet the requirements set out in the Mental Health Act code of practice.

At this inspection we found that staff had begun to regularly inform detained patients of their

rights under the Mental Health Act when they were well enough to do so. Patients were made aware of, or knew how to access independent advocacy services.

However we remained concerned about some aspects of the application of the MHA and code of practice:

- We reviewed one patient who was in long-term segregation. The historical and current risks in the risk assessment were indistinguishable making it impossible to establish a timeline of incidents and to determine what had happened since the previous review. Managers did not have a system in place to review and improve the quality of care and documentation.
- The care plan identified a daily review by the psychiatrist. Records showed reviews took place on five occasions in December 2016.
- There was a lack of formal risk assessment prior to the patients going on any leave. We were concerned about one patient who had significant risk, where there was no crisis or contingency plan describing what staff should do if they encountered a problem whilst the patient was on leave.
- We saw entries in the contemporaneous notes referring to leave conditions for an informal patient. We did not see evidence in the patients file that staff had discussed conditions with the patient. An informal patient has the right to leave unlike a detained patient who may have Section 17 conditions applied to their leave.
- We did not see any signs on the wards explaining the rights of informal patients and staff we spoke to were not always clear which patients were informal and who was detained under the MHA.

Good practice in applying the Mental Capacity Act

At our last inspection, we identified that only 33% of staff had received training in the Mental Capacity Act (2005).

- During this inspection, we identified that training attendance had significantly improved with 87% of staff receiving MCA Training.

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

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

This was a focussed unannounced inspection and we did not inspect this domain.

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

This was a focussed unannounced inspection and we did not inspect this domain.

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

Good governance

At our last inspection, we had identified that there was not always an accurate, contemporaneous record of care and treatment.

During this inspection we found that:

- The managers had implemented a care plan audit, however; this had not led to improved care records. We reviewed the care records of ten patients. None of the records consistently demonstrated accurate and complete records of care. Descriptions of incidents lacked detail. Staff did not clearly record outcomes from interventions. Managers had not developed a system for capturing these concerns and addressing them. There was a lack of evidence of effective oversight and review of care plans by senior staff.

At our last inspection, we had identified that the hospitals environmental ligature risk assessments had not been reviewed since the hospital started admitting patients.

During this inspection we found that:

- Managers had updated the ligature assessment. There were some risks not identified, we alerted the Director of Nursing who took immediate action to rectify this. Further work was planned to continue to improve the safety of the environment.
- Closed circuit television cameras were in operation in the hospital; however, there were no signs advising patients it was in place.

At our last inspection, we identified that managers had not been reporting notifiable incidents to the CQC in a timely manner.

- During this inspection, we saw a considerable improvement in staff reporting incidents to the CQC. We reviewed the incident reports and all notifiable incidents had been reported to the CQC as well as being reported through the hospitals own system.

At our last inspection, we had identified that staff were not up to date with their mandatory training.

- During this inspection there had been considerable improvement and the compliance rate was 84% against a rate of 63% at the last inspection.

At our last inspection, we had identified that the provider did not comply with all policy and practice to meet the requirements set out in the Mental Health Act code of practice.

- During this inspection we found continued concerns about the application of the MHA as set out under the effective domain.

At our last inspection, some clinical audits did not have an action plan to address the concerns identified in the audit.

- During this inspection, we saw evidence of managers developing clinical audit tools. This was still in its infancy and required further development. For example, care plan and records audit tools focused on the existence of the document rather than the quality of the information. There remained some areas of poor practice, identified throughout this report, that had not been highlighted through internal audit and management systems. Managers told us they have plans to improve in these areas but this was yet to lead to improvement.

At our last inspection, the risk register did not reflect all risks found at the hospital.

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

- During this inspection we saw that the risk register had been updated to include clinical as well as business risks. Managers provided information on further planned improvements to procedures to manage organisational risk. An assurance framework was in development and the risk policy was being updated. Governance arrangements had been strengthened to include clearer terms of reference and set agendas for meetings. The board was sighted on key organisational risks.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Following our inspection in January 2017 we told the provider they must improve in the following areas:

- The provider must ensure that all staff are up to date with Mental Health Act training.
- The provider must ensure that all qualified staff receive immediate life support training.
- The provider must ensure that all incidents are reported via their internal reporting process.
- The provider must ensure there are appropriate systems in place to learn from incidents and share that learning with all staff.
- The provider must ensure that staff monitor and record the physical health of patients who have received rapid tranquillisation.
- The provider must ensure that the escorting of patients around the building is based on a clinical assessment of individual risk.
- The provider must ensure that care plans are completed fully and are detailed, and based upon individual risk assessment. The risk assessments must be updated regularly, with clear management plans in place.
- The provider must ensure that physical health nursing assessments are completed and areas of need are addressed.
- The provider must ensure that contemporaneous notes are legible, detailed, in chronological order and reflect patient progress.
- The provider must ensure that all clinical audits have an action plan in place to address the quality of care and concerns identified.
- The provider must ensure that the Mental Health Act Code of Practice (2015) is adhered to in the respect of caring for patients in long-term segregation.
- The provider must ensure patients are aware where closed circuit television is in operation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not comply with all the policy and practice to meet the requirements set out in the Mental Health Act code of practice. • The provider did not ensure patients were aware that closed circuit television was in operation. **This was a breach of Regulation 17**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing • Immediate life support training was not provided for staff. • Not all staff received Mental Health Act training. **This was a breach of Regulation 18**

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment:** • Patient care plans were not completed fully, lacked detail, and were not based upon individual risk assessment. • Patient's contemporaneous notes, care plans and risk assessments lacked detail, where not always legible, where not always in chronological order and did not reflect the patients progress. • Nursing assessments were not routinely carried out. Physical health needs were not being identified and addressed. • Escorting of patients was not based on a clinical assessment of individual risk. • Some incidents were not updated on individual risk assessments and care plans. • Immediate life support training including use of a defibrillator was not provided for staff. • The recording of rapid tranquillisation was incomplete and nurses did not consistently monitor the physical health of patients who had received this. **This was a breach of Regulation 12**

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

This section is primarily information for the provider

Enforcement actions

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Were clinical audit had been undertaken there was not always evidence of action to address the issues found or improvement in care.
- Incident forms were not always being completed by staff as expected.
- The structure for staff to learn lessons from incidents was not robust.
- There was not always an accurate, complete contemporaneous record of care and treatment.

This was a breach of Regulation 17