Nightingale Hospital

Quality Report

11-19 Lisson Grove,
Marylebone,
London,
NW1 6SH
Tel: 020 7535 7700
Website: www.nightingalehospital.co.uk

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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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

We rated The Nightingale Hospital as good because:

- Staff delivered individualised care plans according to patients' needs. Patients had access to group therapy programmes and one-to-one sessions.
- Staff showed a good understanding of the Mental Health Act Code of Practice and its guiding principles.
- In the patient satisfaction survey, patients spoke highly of care and treatment from nursing staff and therapists.
- Patients had access to a large range of rooms and equipment to support their treatment and therapy.
- Staff supported patients with complaints. Information was available in the form of a leaflet or poster.
- Patients had a good choice of meals. Patients we spoke with told us the quality of food was good and had no complaints.
- Staff understood the values of the organisation. Staff were aware of senior managers in the organisation and told us they regularly visited the ward.

However:

- The provider had not addressed ligature risks in its environmental risk assessment. Environmental risk assessments did not indicate timescales for work to address identified ligatures. Examples of ligatures included en suite bathrooms in patients' bedrooms that had standard tap fittings.
- We tested the defibrillator on the second floor and it was not charged. This was a risk to patients if they needed cardiac treatment as it could result in delays in patients receiving urgent care in an emergency.
- Wards did not have wall-based fixed alarms and staff did not have personal alarms. Staff felt unsafe if there were challenging patients admitted to wards.
- On three occasions staff had not carried out physical observations after administering rapid tranquilisation with no rapid tranquilisation audit system in place to monitor use.
- Staff knew how to report an incident and senior management gave us examples on how they had learnt from incidents. When we asked staff on wards for instances of learning they did not provide any clear examples.
- Staff mitigated risk of harm through hourly observation-based risk assessments but did not have access to an overview of updated risks in one place. Risks were stored and updated in different places in patient files, meaning staff had to look in several different places to find the information. How staff developed a plan to mitigate risk was unclear.
- We reviewed documents that recorded multiple incidents of restraint (intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others, or to property and/or equipment) on one form. Staff had not indicated the amount of time they had restrained patients held in the prone (placing a person face down) position.
- Some informal patients did not always clearly understand their rights.
- The privacy and dignity of patients was not maintained on the young persons unit. When conducting routine observations of patients, members of staff often were not considerate and woke patients in the middle of the night. Male members of staff who were completing observations on female patients were routinely entering female sleeping areas at night compromising privacy and dignity.
- Two patients told us they did not have a copy of their care plan.

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	Good	• Staff delivered individualised care plans according to patients' needs. Patients had access to group therapy programmes and one-to-one sessions. • Staff showed a good understanding of the Mental Health Act Code of Practice and its guiding principles. • In the patient satisfaction survey, patients spoke highly of care and treatment from nursing staff and therapists. • Patients had access to a large range of rooms and equipment to support their treatment and therapy. • Staff supported patients with complaints. Information was available in the form of a leaflet or poster. • Patients had a good choice of meals. Patients we spoke with told us the quality of food was good and had no complaints. • Staff understood the values of the organisation. Staff were aware of senior managers in the organisation and told us they regularly visited the ward. However: • The provider had not addressed ligature risks in its environmental risk assessment. Environmental risk assessments did not indicate timescales for work to address identified ligatures. Examples of ligatures included en suite bathrooms in patients' bedrooms that had standard tap fittings. • We tested the defibrillator on the second floor and it was not charged. This was a risk to patients if they needed cardiac treatment as it could result in delays in patients receiving urgent care in an emergency.

Summary of findings

- Wards did not have wall-based fixed alarms and staff did not have personal alarms. Staff felt unsafe if there were challenging patients admitted to wards.
- On three occasions staff had not carried out physical observations after administering rapid tranquilisation with no rapid tranquilisation audit system in place to monitor use.
- Staff knew how to report an incident and senior management gave us examples on how they had learnt from incidents. When we asked staff on wards for instances of learning they did not provide any clear examples.
- Staff mitigated risk of harm through hourly observation-based risk assessments but did not have access to an overview of updated risks in one place. Risks were stored and updated in different places in patient files, meaning staff had to look in several different places to find the information. How staff developed a plan to mitigate risk was unclear.
- We reviewed documents that recorded multiple incidents of restraint (intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others, or to property and/or equipment) on one form. Staff had not indicated the amount of time they had restrained patients held in the prone (placing a person face down) position.
- Some informal patients did not always clearly understand their rights.
- Two patients told us they did not have a copy of their care plan.

Child and adolescent mental health wards

Not sufficient evidence to rate

- Staff delivered individualised care according to patients' needs. Patients had access to group therapy programmes and one-to-one sessions.

Summary of findings

- Staff showed a good understanding of the Mental Health Act Code of Practice and its guiding principles.
- In the patient satisfaction survey, patients spoke highly of the care and treatment provided by nursing staff and therapists.
- Patients had access to a large range of rooms and equipment to support their treatment and therapy.
- Staff supported patients with complaints. Information was available in the form of a leaflet or poster.
- Patients had a good choice of meals. Patients we spoke with told us the quality of food was good.
- Staff understood the values of the organisation. Staff were aware of senior managers in the organisation and told us they regularly visited the ward.

However:

- The provider had not addressed ligature risks in its environmental risk assessment. Environmental risk assessments did not indicate timescales for work to address identified ligatures. Examples of ligatures included en suite bathrooms in patients' bedrooms that had standard tap fittings.
- Wards did not have wall-based fixed alarms and staff did not have personal alarms. Staff felt unsafe if there were challenging patients admitted to the ward.
- Staff knew how to report an incident and senior management gave us examples on how they had learnt from incidents. When we asked staff on the ward for instances of learning they could not provide any clear examples.
- Staff mitigated risk of harm through hourly observation-based risk assessments but did not have access to an overview of updated risks in one place. Risk assessments were stored and

Summary of findings

updated in different places in patient files, meaning staff had to look in several different places to find the information. How staff developed a plan to mitigate risk was unclear.

- Staff had not received specialist training in addition to mandatory training. Nurses on the young persons' unit were generic nurses and did not have a CAMHS background.
- The privacy and dignity of patients was not maintained on the young persons unit. When conducting routine observations of patients, members of staff were often not considerate and woke patients in the middle of the night. Male members of staff who were completing observations on female patients were routinely entering female sleeping areas at night compromising privacy and dignity.

Summary of findings

Contents

Good

Nightingale Hospital

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards;

Summary of this inspection

Background to Nightingale Hospital

Nightingale Hospital is an independent hospital that provides mental healthcare and treatment for people who may or may not be detained under the Mental Health Act 1983. The hospital offers general psychiatry, eating disorder and addiction treatment to adults; and general psychiatry and eating disorder treatment to young people (adolescents).

The service provides three acute wards for adults of working age, and one child and adolescent mental health ward. All wards are mixed sex accommodation. The hospital has 59 beds over the four wards. We focused on the acute and CAMHS wards during our inspection.

The ground floor ward is an 11-bed acute ward. The young persons' unit (first floor) is a 12-bed children and adolescent mental health ward. The second floor ward is a 17-bed acute ward. The third floor is a 10-bed acute/addictions ward. The hospital has recently reshuffled its services on the third floor and we did not include addiction services in the inspection.

On the three days of the inspection there were 37 patients admitted to the hospital. Two of these patients were detained under a section of the Mental Health Act.

We have inspected the Nightingale Hospital three times since December 2011 and published reports of these inspections between January 2012 and January 2015. At the last inspection, the Nightingale Hospital did not meet three essential standards: Consent to care and treatment, Care and welfare of people who use the services, and Safety and suitability of premises.

Our inspection team

The team that inspected the Nightingale Hospital comprised ten people. This included one inspection manager, a mental health act reviewer, three inspectors, and specialist advisors consisting of a consultant psychiatrist, a clinical fellow, a therapist, a senior nurse and one expert by experience. The expert by experience had expertise in relation to health services through using them.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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 asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 14 patients who were using the service;
- spoke with the registered manager and senior managers of the service and five charge nurses.

Summary of this inspection

- spoke with 17 other staff members; including doctors, nurses, health care support workers, therapists and psychologists.
- received feedback about the service from three care co-ordinators or commissioners;
- spoke with an independent advocate;
- attended and observed one management handover meeting, one charge nurse meeting and a peer development practice group.
- Attended and observed a ward community meeting.
- collected feedback from 2 patients using comment cards;
- Looked at 11 care and treatment records of patients:
- carried out a specific check of the medication management on all wards; 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

During our inspection, we spoke with 14 patients. Most of the feedback we received was positive. We also received two completed comment cards from patients. All of the comment cards were positive and talked about the excellent support they received from staff.

Patients told us they had a good level of privacy and that the ward was comfortable and clean. Patients did not like the checks at night and felt it disturbed their sleep. On the young persons' unit, female patients also did not like male members of staff doing checks at night. A minority of patients told us they felt staff could be more attentive but the majority did not agree with this.

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?

Requires improvement 

We rated safe as **requires improvement** because:

- The provider had not addressed ligature risks in its environmental risk assessment. Environmental risk assessments did not indicate timescales for work to address identified ligatures. Examples of ligatures included en suite bathrooms in patients' bedrooms that had standard tap fittings.
- The hospital wards were mixed sex accommodation. The provider had not grouped bedrooms to ensure as much gender separation as possible and there was no female only lounge. This was a breach of the Mental Health Act Code of Practice 8.25/8.26 and Department of Health guidance regarding same sex accommodation.
- Staff had not recorded daily checks in the clinic rooms on the second floor ward. When we tested the automatic external defibrillator (AED), it was not charged and not ready for use. This was a risk to patients if they needed emergency cardiac resuscitation treatment.
- The provider had not robustly monitored safeguarding alerts and there was no process to maintain an overview of safeguarding concerns in the hospital. Staff had shared two child safeguarding concerns with a GP but had not directly escalated this to social services.
- Wards did not have wall based fixed alarms and staff did not have personal alarms. Staff felt unsafe if there were patients who exhibited behaviours that challenged admitted to wards.
- Staff we spoke with knew how to report an incident but were not able to identify examples of learning from incidents.
- A formalised risk assessment document relating to patients safety with an overview of all updated risks was not accessible in one place. Risks were stored and updated in different places in patients' records meaning that staff had to look in different places to find it.
- The provider did not appropriately record all incidents of restraint.

However:

- The provider mitigated risk well through observation and recorded this in sections of the risk assessments. Staff involved patients in risk assessments who self-assessed themselves.

Summary of this inspection

- The provider had good policies and procedures for use of observation.
- We observed staff supporting patients that needed extra support. Charge nurses could adjust staffing levels as necessary.

Are services effective?

Good

We rated effective as **good** because:

- Staff assessed patients comprehensively on admission using an assessment booklet that included mental and physical health needs.
- Patients on wards had access to group therapy programmes and one to one sessions that catered to their needs.
- The hospital had a large number of consultant psychiatrists (over 50 with practice rights), psychologists and sessional therapists that worked with patients on an individual basis.
- Patients had access to specialist physical health treatment for physical health problems such as cardiovascular assessment .
- Staff showed a good understanding of the Mental Health Act, and the Code of Practice

However:

- Some informal patients did not understand their rights. The provider had placed leave restrictions on them, which staff had not agreed with the patient.
- Staff did not receive specialist training in addition to mandatory training. Nurses on the young persons' unit were generic nurses and did not have a CAMHS background.
- The provider did not have MDT meetings due to the large number of consultants at the hospital. There were issues with communication amongst staff who did not meet face to face.

Are services caring?

Good

We rated caring as **good** because:

- We observed positive interactions on wards between staff and patients.
- Patients had access to an independent advocate.
- Patients spoke highly of care and treatment from nursing staff and therapists in the patient satisfaction survey.

However:

Summary of this inspection

- Some patients told us staff were not as available as they would like For example, we spoke with patients who felt staff were always at the nursing office.
- Patients on the young person's unit spoke negatively about privacy and that told us that male members of staff were checking female bedrooms at night and that they woke them up during observations by shining torches in their eyes.

Are services responsive?

Good

We rated responsive as **good** because:

- The average bed occupancy percentage across the last six months was 72.8%. This was below the Royal College of Psychiatrists recommended optimum occupancy rate of 85%.
- Patients had access to a large range of rooms and equipment to support their treatment and therapy.
- Patients knew how to make a complaint. Staff supported patients with complaints and information was available in the form of a leaflet or poster.
- Patients we spoke with told us the quality of food was good and had no complaints.
- The choice of food met dietary requirements of religious and ethnic groups.

However:

- Patients did not have access to a dedicated quiet area on wards.
- The provider did not have did not have dedicated multi faith rooms within wards and a room had to be found for spiritual support.
- Staff we spoke with were unable to tell us the number of complaints that occurred on each ward. Staff told us they did not receive feedback about complaints for example analysis or evaluation of themes**.**

Are services well-led?

Good

We rated governance as **good** because:

- Staff understood and agreed with the values of the organisation. Staff were aware of senior managers in the organisation and told us they regularly visited the ward.
- Staff had the opportunity to take part in the mentorship programme which allowed support to new or less experienced staff.

Summary of this inspection

- The provider used key performance indicators (KPIs) to gauge the performance of the team. This included patient satisfaction, complaints, incidents, environment, health and safety and clinical outcomes.
- Staff felt their managers were supportive and Junior Doctors said consultants were very helpful.

However:

- Charge nurses had limited access to information that was relevant to the wards they managed.
- Staff completed a clinical notes audit which reviewed patient records for errors and mistakes. The audits we reviewed, MHA and capacity and consent audits demonstrated they were regularly undertaken. However, we did not see evidence the provider had addressed actions identified in the clinical notes audit.

Detailed findings from this inspection

Mental Health Act responsibilities

- Seventy-two per cent of staff had received training in the Mental Health Act 1983 (MHA). Staff showed a good understanding of the Mental Health Act, Code of Practice and guiding principles. Informal patients on the young person's unit were given and asked to sign a "consent to management of physically disturbed or violent behaviour" contract. We reviewed this contract and did not think it was appropriate as all informal young persons were expected to agree to be physically restrained. The use of restraint is an indication that an assessment is required under the MHA. This was not an advanced directive based on the wishes of patients.
- Capacity to consent to treatment (under part IV of the Act) forms were completed, but generic. One patient record we reviewed had a description of symptoms as opposed to what the treatment was which was unclear. MHA documentation in the service was good.
- Staff were aware of who they needed to contact for advice regarding the MHA. A senior manager supported adherence to the MHA.
- Patients had access to an independent mental health advocate. Staff displayed posters and leaflets on wards with information about the MHA/

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety-five per cent of staff had training the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had a good understanding of MCA 2005, in particular the five statutory principles.
- The hospital had a policy in place to support staff in the use of the MCA and DoLS.
- The provider made no DoLS applications in the previous six months.
- For people who might have impaired capacity, staff assessed and recorded capacity to consent appropriately. They helped patients make important decisions for themselves before reaching a conclusion on whether they lacked the mental capacity to do so.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- Staff were aware of who they needed to contact for advice regarding the MCA and Gillick competency (whether a child -16 years or younger- is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). A senior manager who prompted staff of their requirements and reminded them of what they needed to do supported adherence to the MCA and Gillick competency.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

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

Good

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

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

Requires improvement

Safe and clean environment

- We visited the ground floor ward, young persons' unit, second floor ward and third floor ward. The wards had poor lines of sight and did not allow staff to observe all areas. Long corridors with no mirrors and bedroom doors without viewing panels made it difficult for staff to observe patients. Corridors at night did not have night lights. Staff used torches for observation and opened patients' bedroom doors. Staff managed this with an hourly observation-based risk assessment. We reviewed patients' risk assessments, which demonstrated staff recorded observation.
- Wards had a number of ligature risks identified through an environmental risk assessment for each ward in the hospital. However, the assessment did not indicate timescales for works to address ligatures and staff did not have a copy of it on the ward. Examples of ligatures points included en suite bathrooms in patients' bedrooms that had standard tap fittings.
- The hospital wards were mixed sex accommodation. Male and female patients shared the same living and sleeping areas but did not share bathrooms, as bedrooms had en suite bathrooms. Despite this, the provider had not grouped bedrooms to ensure as much gender separation as possible and there was no female only lounge. This is not in line with the Department of Health guidance regarding same sex accommodation.
- Wards had fully equipped clinic rooms that were generally clean, organised and tidy. There were emergency medicines and equipment available on all wards. On the third floor ward and young persons' unit, staff conducted and recorded daily checks and equipment had up to date stickers. On the second floor, staff had not conducted daily checks in clinic rooms. They had not recharged an automatic external defibrillator (AED) that after previous use which was a risk to patients having to wait for cardiac medical treatment. We did not find fridge temperature recordings for September despite other months being present. We also observed prescribed medicine in the medication room which should have been locked away. On the ground floor ward, staff had not noted and identified that the sticker to check oxygen in the oxygen cylinder was out of date. There was a risk to patients if they required emergency from out of date equipment and we raised this with the hospital.
- The hospital did not have seclusion rooms. The provider referred patients to an alternative hospital if they required nursing in seclusion. The hospital assessed patients before admission and only admitted patients whose needs they could meet.
- All wards were well maintained, were clean and had good furnishings. Cleaning records we viewed were up to date and patients we spoke with felt the wards were very hygienic. Hand washing facilities were available on all wards and hand hygiene audits were regularly completed. The weekly environmental risk assessment identified maintenance needed on the wards and highlighted broken or damaged items.
- Wards did not have a wall based fixed alarms along corridors and staff did not carry personal alarms. Staff were unsure what would happen if an incident

occurred. Staff told us they had requested personal alarms for a number of years. There had been discussions between charge nurses and senior managers in regards to obtaining bleep alarms. The provider had not implemented this at the time of the inspection. This concerned us as some staff felt it could be unsafe if they had challenging patients. Bedrooms and bathrooms had call alarm systems on all wards.

Safe staffing

- Staff vacancy rates were 41% across the hospital at the end of August 2015. There were vacancies for 14 qualified nurses and six healthcare assistants. Senior managers were actively recruiting to fill positions. The charge nurses were not involved in the recruitment of nurses.
- The provider filled vacancies with bank staff. Staffing levels were safe and vacancies had not impacted safety on the ward. Bank staff were from a pool of permanent workers used by the provider who worked additional shifts. The provider had a six-month contract with two agencies and their staff were familiar with the ward. At the time of the inspection, the provider employed two agency staff on fixed term contracts. The provider also used bank and agency staff to cover for sickness and annual leave.
- The provider submitted information prior to the inspection showing that the total number of substantive staff for the hospital was 130 (as at 31 August 2015). The total number of staff leaving in the previous 12 months was 21. Staff turnover from September 2014 – August 2015 was 16% of substantive staff. The nursing manager post was vacant and in the process of being recruited. The clinical services director and deputy hospital director and charge nurses split duties usually maintained by the nursing manager. Charges nurses were supernumerary on the ward.
- Charge nurses maintained safe staffing levels on each ward. The provider established staffing levels using a recognised tool and met the needs of patients. As a baseline, the provider had one qualified nurse for every three patients and a health care assistant on each floor.
- Charge nurses used a recognised tool to estimate the number of staff and could request additional staff when needed. For example, when a patient needed one to one support or increased observation. Some of the patients we observed needed extra support because of physical disability and we observed staff giving this support to patients. Staff and patients told us charge nurses never cancelled leave due to staffing levels. From June 2015 to August 2015, bank or agency staff covered 1575 shifts.
- Ward Doctors were on site from 9am - 5pm Monday to Friday. At the weekend and after 5pm a doctor provided on-call medical cover at night.
- Mandatory training was a mixture of face-to-face training and e learning. A training administrator monitored compliance with training. The administrator disseminated training figures to senior staff to address areas of non-compliance. The provider was in the process of moving to a new system to monitor mandatory training and had a plan to reach a 100% completion rate by the end of December 2015. The aim was for staff to have completed all training by the end of November. Training included health and safety, fire safety, manual handling, safeguarding, mental health act, mental capacity act and diversity training. At the time of our inspection, the provider gave us information about completion rates for mandatory training. Staff had completed 81% of mandatory training modules. Four elements of training showed less than a 75% completion rate including health and safety training which was at 74% and mental health act training at 72%.

Assessing and managing risk to patients and staff

- A risk assessment was completed on admission, however this was not reviewed and updated during the period of inpatient care and treatment. It was unclear how staff developed plans to mitigate risk. Staff regularly documented risk in progress notes and used a tick box form for general observation of patients. Patients self-assessed their risk through a twelve point sticker that listed factors such as drug and alcohol use and if it was a low, medium or high risk. Therapists documented and recorded therapy sessions and recorded the type of session but risks that may have risen from therapy sessions were not. We did not find evidence of notes for patients who had one to one sessions with therapists. When staff needed to view a patients' history and current risks, there was no single place within the patient notes where this was available. Whilst staff monitored risk regularly, the absence of a formalised system to capture and review potential risks in one placement staff did not have a clear understanding of the overall risk of a patient.

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

Good

- There were some blanket restrictions in place across the wards. The provider had justified restrictions on contraband items including shoelaces and belts (if at risk), sharps, nail clippers, tweezers, razors, alcohol and medication. Patients did not have keys to their bedrooms and patients we spoke with indicated they would like keys to their bedrooms. Staff we spoke with did not recognise this as a restrictive practice.
- One informal patient we spoke with told us staff did not allow them to leave the hospital. We reviewed the patient's records, which showed a consultant recommended that the patient should not have unescorted leave. We did not see evidence of staff discussing and agreeing this with the patient, or completing a capacity assessment. The patient did not clearly understand their rights and was unclear on the restrictions put in place by the provider.
- The provider had appropriate policies and procedures for use of observation. Wards used four levels of observation based on daily risk assessments that ranged from hourly to close observation. Bedroom doors did not have viewing panels so at night staff were required to open doors for observation checks. Patients we spoke with did not like this and felt it disturbed them at night.
- The provider had a policy on the management of disturbed or violent behaviour. Staff we spoke with told us the use of restraint was rare and that they used de-escalation techniques. The records we reviewed did not demonstrate accurate recording of restraint. Between 1 January 2015 and 31 August 2015, staff had used restraint on 33 occasions. In seven (21%) of these incidents the prone position was used for a very small group of patients. We reviewed the records of a patient who was restrained on twelve occasions in ten days. The provider had carried out an investigation into the patients' admission and treatment using a root cause analysis (RCA).
- The route cause analysis indicated that some agency staff did not have appropriate Prevention and Management of Violence and Aggression (PMVA) training and they were observed using inappropriate restraint holds. As a result the provider subsequently worked with booking agencies to ensure that all staff employed had appropriate levels of PMVA training. The RCA also indicated that on some occasions more than one incident of restraint was reported on one incident form.
- Overall, the restraint reports we reviewed showed that staff were; not clearly recording the hold used, which staff were involved, which points of the body they were deployed and how long the hold was maintained.
- Between 1 January 2015 and August 2015, staff used rapid tranquilisation on 20 occasions. There was evidence that rapid tranquilisation was identified as being administered to one patient on at least three occasions and that physical observations were not carried out following the use of rapid tranquilisation. No rapid tranquilisation audit system was in place to monitor use. However the provider had completed a RCA and identified concerns that addressed rapid tranquilisation in its report. Staff we spoke with knew how to make a safeguarding alert, could explain different safeguarding concerns and were aware of the safeguarding lead for the provider. Staff received training in safeguarding as part of their mandatory training at three levels based on their role. Only 68% were up to date with safeguarding level three and just 52% were up to date with safeguarding children at level three. This meant that nearly half of the staff required, had not completed safeguarding children at level three. The provider planned for all staff to have completed this training by December 2015.
- The provider maintained a safeguarding spread sheet, which contained details of all recent safeguarding concerns, the actions taken and the outcome. When a safeguarding concern was raised, the local authority were contacted and action taken. We also reviewed ten safeguarding records. However, in two cases where the hospital had identified a potential child safeguarding concern, they were shared with a GP but there was no evidence that contact was made with social services to advise them of these concerns, although the provider was aware that children's social services were involved with these families. The provider had not directly escalated child safeguarding concerns to social services.
- The provider had a named contact for adult safeguarding in the Westminster local authority. Staff and local authorities discussed safeguarding concerns by telephone and email. For children there was also a local authority contact. In addition the provider attended quarterly child protection safeguarding forums with the local authority.
- The provider had a policy in place for children's visits and staff were aware of this. Permission for children to

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

Good

visit would only be granted when the clinical team considered it safe and in the child's best interests. Staff told us they would try and find a room off the ward but visits also took place in patients' bedrooms.

Track record on safety

- In the last six months there was one serious incident involving a patient who had been attending day services at the hospital. The investigation was not robust in terms of learning and reflection. The RCA did not address care and service delivery, root causes or lessons learned. There were no recommendations made as part of the RCA.
- Staff completed a second RCA where a patients' mental state had deteriorated during admission. The provider identified concerns that included the frequency and numbers of restraint, high doses of medication administered, the use of rapid tranquilisation and agency nurses observed using inappropriate holds as a concern. We reviewed a sample of incidents for the last three months. Incident reports included a summary of the incident and a risk rating. However, there was a risk that the provider was not giving appropriate ratings. They had given a risk rating for an incident involving a suicide attempt the same as that for a patient caught smoking in their bedroom. The provider told us that the rationale for this would have been discussed at the time of the incident. However, this was not included in the incident report and no further information was made available to us as the patients records had been archived.
- The provider had an open and honest policy that had been updated in June 2015 to commit to being open and honest in line with duty of candour requirements.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to report incidents. Staff recorded incidents on electronic forms then sent them to be investigated by a senior manager. We were confident that staff and managers reported all incidents.
- The provider demonstrated that some learning from incidents took place and that information was shared with staff through the intranet. A review of incidents for themes and issues had resulted in the development and implementation of a self-harm pathway across all wards. Each pathway had a steering group that reviewed all incidents within their service. However, staff could not describe changes made as a result and did not give us any examples. An example of this would be an incident file we reviewed, which had a controlled drug error where a tablet went missing. We did not see any further investigation of this or updates within risk assessments. Staff felt that feedback and learning was rare and that it could be improved and discussed more, for example in weekly nursing meetings.
- Staff debriefed after incidents. They told us the debriefing learning exercises were useful after a near miss or a serious incident. Staff debriefed patients involved in incidents and discussed reasons why incidents had happened.
- Staff received support after incidents, including support from therapists if needed.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed the care records of 13 patients across all four wards. Staff had assessed patients comprehensively on admission. Assessments included both physical and mental health needs. The provider had introduced a new assessment booklet since their last inspection.
- A doctor undertook physical examinations and blood tests on admission. Patients had an electrocardiograph (ECG), blood and weight checked within 48 hours. Staff monitored patients physical health needs on an on-going basis.
- Staff reviewed and updated care plans regularly. Staff discussed patients' activities and behaviours with them, whilst there was evidence that patients had agreed to statements of treatment it was not clear that patients understood these. This meant that care plans were not always person centred or recovery orientated. Discharge forms were supposed to be completed upon admission but we did not see evidence of this

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

Good

- Information needed to deliver care was stored securely and available to staff when they needed it. Records were stored on a paper-based system securely in the nursing office. The provider was moving to an electronic system in January 2016.

Best practice in treatment and care

- Staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. For example when prescribing medicines and psychological interventions.
- Patients on all wards had access to a group psychological therapy programme. The provider catered the programme to their needs and this included Cognitive Behavioural Therapy, Interpersonal Psychotherapy and Dialectic Behavioural Therapy. Patients also had the option to have a one to one at the end of therapy with a psychologist. A consultant psychiatrist agreed care packages upon admission with patients. Staff sent reviews of progress in therapies to consultants.
- Patients had access to specialist physical health care when needed. Doctors referred patients to specialists where abnormal tests or physical health issues arose. Staff arranged appointments and escorted patients to appointments.
- Staff used a client self-report questionnaire designed to be administered before and after therapy. The provider used the Clinical Outcome in Routine Evaluation –Outcome Measure (CORE-OM) to gauge responses to questions and indicate the level of psychological distress. The hospital also used health of nation outcome scales (HoNOS), Goal Attainment Scaling (GAS) and the Eating Disorder Examination Questionnaire (EDE-Q).
- Therapists discussed attendance and incidents with nurses in handover meetings after therapy sessions. Staff told us attendance was high. Therapists could also visit and review patients on wards.
- Staff participated in clinical audits. For example, staff had a continuous audit of admission times, administration of night sedation and capacity.

Skilled staff to deliver care

- The hospital had a full range of mental health disciplines and workers to provide care and treatment. These included nurses, doctors, occupational therapists, psychologists, pharmacists, therapists and support workers. The hospital had a large number of consultant psychiatrists (over 50 with practice rights), psychologists and sessional therapists that worked with patients on an individual basis.
- Staff did not receive specialist training in addition to mandatory training. Staff raised this issue in the past and felt that they did not receive enough specialist training. Nurses on the young persons' unit were generic nurses and did not have a CAMHS background. Staff did receive training from a lead therapist and felt this was useful but indicated they would like more specific training, for example, on eating disorders or addiction. We did not see any evidence that the provider planned to offer specialist training in the future.
- New staff received an induction when they started working at the provider. This included mandatory training and prevention of violence and aggression. Agency and bank staff also had an induction to ensure they were familiar with the wards.
- Permanent staff received supervision every four to six weeks. The clinical services director and deputy hospital director and charge nurses jointly managed this through a matrix. Bank staff were supposed to receive supervision every six to eight weeks but there was no matrix available to see if this was taking place. In addition to one-to-one supervision, open group supervision was available to all staff. Permanent staff we spoke with felt they received supervision regularly. However, some bank staff told us that they had not received supervision.
- Charge nurses and senior management explained the process around performance management and how staff with poor performance would be managed.

Multidisciplinary and inter-agency team work

- Wards did not have multidisciplinary team meetings. Consultants and junior doctors held discussions regarding patients and the junior doctor would then convey this to charge nurses. Staff felt this method of communication was an issue as the majority of staff did not meet each other and contact was through email and by telephone. Examples of this included staff not recording verbal feedback in patient records and disagreements regarding issues such as observation levels. There was a risk that this could lead to incorrect recording information and have a detrimental effect on patient safety.

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

Good

- Each ward had effective nursing handovers twice a day. We did not observe a handover meeting during our inspection but feedback from staff was positive. Staff used handovers to discuss changes in observation levels and incidents. Senior staff had a daily management meeting and discussed incidents, observation levels, risk assessments, admissions and discharges.
- Charge nurses had a weekly meeting with the clinical services director and deputy hospital director. We observed one of these meetings and staff reviewed issues such as information governance, environmental risk assessments, observation levels, incidents and complaints.
- Consultants had a weekly medical meeting with the clinical lead. Staff we spoke with told us they tried to attend this meeting as often as possible. They used the meeting discuss individual cases and feedback as well as review of journal articles for better practice.
- The hospital had positive working relationships with teams outside of the organisation. Communication with other agencies and organisations was good. There were links with local hospitals and patients had access to specialist treatment centres. We spoke with six GPs who felt the clinical and medical staff were approachable and supportive.
- The advocates we spoke with felt that the hospital responded to instructions from patients with respect, promptness and professionalism at all times in a polite and dignified manner. However, they felt the provider could improve in respect to information provided to informal patients about their right to leave the hospital building. The advocates told us they introduced themselves to patients and outlined patients' rights and options. However, despite information displayed in the hospital, it became apparent that informal patients were still under the impression that they had no right to leave the hospital.

Adherence to the MHA and the MHA Code of Practice

- Seventy-two per cent of staff had received training in the Mental Health Act 1983 (MHA). Staff showed a good understanding of the Mental Health Act, Code of practice and guiding principles. Informal patients on the young persons unit were given and asked to sign a "consent to management of physically disturbed or violent behaviour" contract. We reviewed this contract and did not think it was appropriate as all informal young persons were expected to agree to be physically restrained. The use of restraint is an indication that an assessment is required under the MHA. This was not an advanced directive based on the wishes of patients.
- Capacity to consent to treatment forms were completed, but generic. One patient record we reviewed had a description of symptoms as opposed to what the treatment was which was unclear.
- On admission, staff explained patients' rights in a way they could understand. From the records we reviewed, there was evidence of a good discussion of rights among patients and staff. MHA Documentation in the service was good. From the records we reviewed, we saw evidence of good discussion of rights and detention papers.
- Staff were aware of who they needed to contact for advice regarding the MHA. A senior manager supported adherence to the MHA.

Good practice in applying the MCA

- Ninety-five per cent staff had training the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had a good understanding of MCA 2005, in particular the five statutory principles.
- The hospital had a policy in place to support staff in the use of the MCA and DoLS.
- The provider made no DoLS applications in the previous six months.
- The provider admitted a patient who was informal then sectioned. Before detainment, staff completed an assessment of capacity form. Staff did not assess the patient as being uncooperative. The progress notes included a brief note on the day of detention that said the patient lacked capacity to understand treatment.
- For people who might have impaired capacity, capacity to consent was assessed and recorded appropriately. Staff did this on a decision-specific basis with regards to significant decisions, and patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it.

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

Good

- Staff supported patients to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- Staff were aware of who they needed to contact for advice regarding the MCA and Gillick competency. A senior manager prompted staff of their requirements and reminded them of what they needed to do supported adherence to the MCA.

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

Good

Kindness, dignity, respect and support

- We observed positive interactions between staff and patients on each ward. Staff were responsive, discreet, respectful, provided appropriate practical and emotional support, and had a good understanding of patients' needs. However, we observed staff who were not aware of a patients name and this compromised their dignity and was not personalised care.
- On the ground floor ward, patients told us staff were very supportive and respectful. However, some patients told us staff were not as available as one would like. For example, one patient told us they did not know what medication they were taking and that they were not given enough information.
- Patients on the young persons' unit spoke highly of the day staff and felt they genuinely cared for their wellbeing. However, some patients did not feel as comfortable with night staff. Patients told us that male members of staff were checking female bedrooms at night and that they woke them up during observations by shining torches in their eyes.
- On the second floor ward, patients told us day staff were kind and attentive but night staff were less positive. Some patients we spoke with felt staff were always at the nursing office and seemed busy.
- We spoke with patients on the third floor ward. Some patients told us nurses were not always visible but they never had to wait long. Patients felt staff were fantastic and felt more like a family to them. They told us staff were attentive and enjoyed the interactions with them.
- We collected two comment cards, all from the third floor ward. Both cards were positive and spoke highly of the care and treatment they received.
- The majority of patients on wards were not from London. The hospital considered needs of visitors and were flexible on visiting times for carers and families. Visitors to the young persons' unit had to be over 18 years old. The provider made exceptions for younger siblings and close friends when accompanied by an adult.

The involvement of people in the care they receive

- Patients were orientated on admission to wards with welcome packs and a tour of the building by service staff. Staff allocated patients a nurse on arrival who went through the care plan with them. Kitchen staff liaised and discussed dietary and religious needs with patients and planned cigarette breaks from admission. For young persons, staff also did an education assessment on admission and liaised with schools. Schools sent work to the hospital and facilitated exams in the hospital.
- Most patients we spoke with said they were involved in their care planning and had received a copy of their care plan. Most patients told us they went through their care plans with their allocated nurses. Some patients we spoke with told us they did not have a copy of their care plan. We reviewed care plans written in the first person and did not evidence involvement from patients.
- Patients knew about the independent mental health advocacy service. The advocate visited wards twice a week. Notice boards provided information on how to contact the advocate. Staff made patients aware on admission of the advocacy service.
- The provider conducted patient satisfaction surveys on a monthly basis. The survey assessed admissions, cleanliness, food, care and treatment, respect, trust, involvement and answering questions. The survey had a target of 93% for responses that were good or excellent. The only indicator under target was the quality of food available.

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

Good

- Community meetings occurred weekly on wards. Patients and staff discussed items such as engagement in therapy groups and plans or activities for the week.

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

- The average bed occupancy percentage across the last six months was 73%. This was below the Royal College of Psychiatrists recommended optimum occupancy rate of 85%.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had a large range of rooms and equipment to support treatment and therapy. Patients had meals in a dining area that all wards had access to across the hospital. Staff used the basement as an area for therapy groups and one-to-one sessions. The second floor had two large areas that patients used as a communal area. Each ward had its own lounge that had a television with a selection of games and newspapers for patients.
- Patients did not have dedicated quiet areas on wards to meet visitors. Staff told us they could find a room for patients to use but that most patients would meet visitors in their bedrooms. On the young person's unit, the providers policy asked visitors not to wander unnecessarily around the ward for the protection of the other young people.
- There was a dedicated phone on wards for patients. Patients asked staff to use the cordless phone at the nursing office and then would take it to their rooms. Patients could also have personal mobile phones and staff risk assessed the use of chargers.
- The provider had a secure outdoor courtyard that adult patients could access during the day for smoking breaks. Staff accompanied young people to the staff courtyard, as they did not have access to the adult courtyard.
- Patients had a good choice of meals available. Patients we spoke with told us the quality of food was good and had no complaints.
- Wards had a kitchen which patients could use to make hot drinks and snacks. The kitchen had storage units and multiple fridges for patients to store their own food.
- Patients did not personalise bedrooms due to the length of stay
- Patients stored personal items in lockable cupboards
- Patients had access to activities and therapy groups throughout the day. At weekends, activities such as yoga were available.

Meeting the needs of all people who use the service

- The provider made adjustments for people requiring disabled access. They used the ground floor ward for patients with disabilities. The provider had a lift if access to other floors was needed. Patients contacted reception upon entrance to enter through a side entrance that was locked.
- Information leaflets were available in different languages for patients who used the service.
- There was information available on treatments, local services, patients' rights and how to complain.
- The choice of food met dietary requirements of religious and ethnic groups.
- Wards did not have a dedicated multi faith room for patients. If patients wished to use a room for spiritual purposes then staff would find a room in the hospital for the patient. Staff adapted facilities for people of different faiths and cultural backgrounds.
- Patients had access to an independent mental health advocate. Wards displayed posters and leaflets with information on advocates.

Listening to and learning from concerns and complaints

- There were 62 formal complaints made between August 2014 and August 2015. The provider upheld 40 of these complaints. The majority of these complaints related to care and treatment. Examples included complaints about therapy programmes and medication errors.
- Patients knew how to complain about the service. Notice boards displayed leaflets explaining the complaints process. The admission pack for patients included information on how patients could make a complaint. Patients we spoke with told us they were aware of the complaints process.

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

Good

- Staff tried to resolve verbal complaints informally on the ward and if not possible, encouraged patients to make formal complaints.
- A senior manager investigated complaints, for which there was a clear process. There were three complaints pathways, depending on the level of intervention needed, ranging from low to high. The target to investigate and respond to complaints was 20 days. The provider held complaints open for response for 15 days and then closed. Complainants could escalate a complaint to the Association of Independent Health Organisations (AIHO) if they were unhappy with the way it was dealt with.
- We reviewed the files of seven complaints between August 2014 and August 2015. Staff had written responses for five of the complaints. The provider had not sent written responses to the other two complaints. The provider fed back the outcome of the investigation in a face-to-face meeting but no records were kept of these meetings.
- Themes and findings of complaints were an agenda item at the Quality and Performance Management Group and was summarised monthly. We reviewed minutes of meetings which demonstrated discussion and learning had taken place. However some staff we spoke with were unable to tell us the number of complaints that occurred on each ward. Some staff told us they did not receive feedback about complaints, for example analysis or evaluation of themes.

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

Good

Vision and values

- The providers values were compassion, respect, commitment, one team and recognition. Staff understood and delivered against the values of the organisation. Staff were aware of senior managers in the organisation and told us they regularly visited the ward.

Good governance

- The provider had a structured governance system in place. A quality and performance management group took place monthly between senior managers. From the minutes we reviewed, items discussed included complaints, feedback from patients, health and safety, incidents, patient care, mandatory training, the mental health act, and safeguarding. Senior management were effective at monitoring vacancies, sickness, complaints, incident reporting and ensuring staff had completed mandatory training. The provider was moving to e learning for the majority of mandatory training. There were initial challenges in implementing the system but it was now up and running. The provider was monitoring uptake of mandatory training and had a plan in place for all staff to have completed 100% of training by December 2015. When we spoke with staff, they were unsure of common themes for complaints and incidents as well as how often they occurred. Staff also noted a lack of feedback and learning from complaints and incidents. Charge nurses did not attend the quality and performance management groups but attended weekly meetings with the clinical services director and deputy hospital director. We did not see evidence of minutes sent to charge nurses. Staff we spoke with told us that they had requested to attend these meetings.
- Staff completed a clinical notes audit which reviewed patient records for errors and mistakes. The audits we reviewed, demonstrated that this was regularly undertaken. However, we did not see evidence of actions being addressed. Actions from the audit included training to be provided, the use of champions in departments, and a monthly review of progress. At the time of our inspection, we did not see specialised training offered, champions across wards or evidence of the audit being reviewed monthly.
- Senior management conducted and kept environmental risk assessments but had not taken action to develop timescales to address identified ligatures. Staff on all wards did not have copies of the ligature assessment audit when we asked to see it. This was a risk, as new staff may not have received a thorough understanding of all ligatures across wards.
- There was a shortage of permanent workers but most staff told us they felt safe working on the wards. Some staff felt they it could be unsafe if they get challenging patients but had raised this with senior managers.
- The provider had a system to record appraisals and supervision. The clinical services director and deputy

hospital director and charge nurses jointly monitored permanent staff appraisals and supervision. Senior managers told us bank staff received supervision but could not produce information that demonstrated this.

- The provider used key performance indicators (KPIs) to gauge the performance of the team. This included patient satisfaction, complaints, incidents, environment, health and safety and clinical outcomes. Annually, the provider focused on two KPIs. At the time of thin section, they were looking at patient feedback. This covered issues such as appropriate information given on admission, cleanliness, food and the helpfulness of non-clinical staff. In addition, the provider was looking at patient satisfaction with regards to respect, trust, and confidence and involvement in care and treatment decisions.
- For one RCA that staff had completed regarding deterioration of a patients' mental state, there was evidence of learning, for example; rapid tranquilisation medication was now available on each ward and bank and agency staff PMVA training was monitored. However there there was no action plan developed as a result of the RCA that systematically addressed each concern and monitored and documented progress in addressing it.
- The provider maintained a risk register. Senior managers used the clinical governance meeting to monitor and escalate instances of risk. Charge nurses did not have access to local risk registers on the ward.

Leadership, morale and staff engagement

- Most staff were positive about the support they received from senior management. However, in contrast some staff on the wards felt less positive about the support from senior management. They felt that there were differences at higher levels in the approach they take and that their opinions could be valued higher. Some staff felt that some concerns were not taken seriously and that this had an effect on staff morale.
- Staff were aware of senior managers and knew who they were. They told us they regularly saw them on the ward and could meet with them when they needed to.
- The overall staff sickness level from September 2014 – August 2015 was 3%.
- Staff knew there was a whistle-blowing process and talked about what they would do if they had concerns that could not be raised with senior managers. Nursing staff felt their managers were supportive. Junior Doctors also said consultants were very helpful.
- Staff had the opportunity to take part in the mentorship programme which allowed support to new or less experienced staff.

Commitment to quality improvement and innovation

- The provider offered Repetitive Trans cranial Magnetic Stimulation Therapy as an alternative to Electric Convulsive Therapy. The principle of the therapy was to target short magnetic pulses over the scalp to produce electrical currents in specific brain regions that regulate mood.

Not sufficient evidence to rate

Child and adolescent mental health wards

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate

Are child and adolescent mental health wards safe?

Not sufficient evidence to rate

Start here...

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Not sufficient evidence to rate

Start here...

Are child and adolescent mental health wards caring?

Not sufficient evidence to rate

Start here...

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

Not sufficient evidence to rate

Start here...

Are child and adolescent mental health wards well-led?

Not sufficient evidence to rate

Start here...

Outstanding practice and areas for improvement

Outstanding practice

Start here...

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure The provider must share child safeguarding concerns with external social services agencies.
- The provider must ensure they are compliant with mixed sex accommodation guidance in line with the Mental Health Act Code of Practice 8.25/8.26.
- The provider must ensure works needed to address ligature risks have a completion date.
- The provider must appropriately audit and record all incidents of restraint (hold, staff, positions on body and length of time).
- The provider must ensure that when rapid tranquilisation is administered, physical health checks are carried out and recorded.
- The provider must ensure daily checks to emergency equipment are recorded and monitored regularly.

Action the provider SHOULD take to improve

- The provider should take appropriate steps to ensure that lessons learned by staff following incidents are implemented and monitored effectively.
- The provider should ensure that all safeguarding concerns within the hospital are documented and escalated to social services in a robust manner.
- The provider should ensure informal patients are aware of their rights .
- The provider should ensure staff have access to alarm systems.
- The provider should ensure emergency equipment is ready for use
- The provider should ensure specialist training for nurses and health care assistants on different pathways, for example addictions and CAMHS.
- The provider should develop effective systems and processes to share information between the MDT.
- The provider should ensure the privacy and dignity of patients is maintained.
- The provider should ensure that staff record sufficient information to manage and mitigate risks in risk assessments.

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 10 HSCA (RA) Regulations 2014 Dignity and respect The provider must ensure they are compliant with mixed sex accommodation guidance in line with the Mental Health Act Code of Practice 8.25/8.26. **This was a breach of regulation 10 (2) (a)**

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 The provider must ensure that when rapid tranquilisation is administered, physical health checks are carried out and recorded. **This was a breach of regulation 12 (2) (a)** The provider must ensure works needed to address ligature risks have a completion date. **This was a breach of regulation 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

This section is primarily information for the provider

Requirement notices

In two instances where potential child safeguarding issues were identified the provider had contacted the patients GP, but had not made contact with social services departments who were already involved with the family, to share the concerns.

This was a breach of regulation 13 (1) (2)

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 The provider must appropriately record all incidents of restraint (hold, staff, positions on body and length of time). Also audit the use of restraint which they are not currently doing. **This was a breach of regulation 17 (2) (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.