St Andrew's Healthcare

St Andrews Healthcare Northampton

Inspection report

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Date of inspection visit: 18 - 20 October 2022
Date of publication: 06/03/2023

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Insufficient evidence to rate
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced focused inspection was triggered by the receipt of information which gave us concerns about the safety and quality of services on one ward in this core service. The information of concern was received by CQC between July and September 2022. Our last comprehensive inspection of this service was in June 2016 and a follow up inspection in May 2017.

The concerns received included the following:

- safe staffing levels and how incidents were safely managed
- physical healthcare and care of the deteriorating patient.

This was a focused inspection, on 1 of 5 wards in this core service and we inspected the key questions of safe, effective and well-led due to the nature of concerns reported to us. This inspection was rated based on our findings.

Our rating of this location went down. We rated it as requires improvement.

We found:

- Leadership on Allitsen ward was not always consistent on day or night shifts. Leadership was not always visible. Leadership changes on the ward had de-stabilised the ward, and governance processes to monitor mandatory training were not used effectively.
- Staff did not always follow the communication processes between Allitsen ward and the physical healthcare team following incidents.
- Managers had not ensured that all shifts had the correct number of qualified nurses for the duration of the shift.
- Not all staff on Allitsen ward were compliant with all mandatory training, and data to monitor compliance was inconsistent.

However:

- Staff managed the routine physical healthcare of patients well and managed physical healthcare incidents well.
- Allitsen ward showed that while nursing shifts had not started with the planned number of staff, managers filled gaps with known bank staff to bring staffing levels up to safe numbers. Staff told us that in the previous few months staffing levels had improved. The provider had improved pay and conditions for staff and had measures in place to address both recruitment and retention of staff.
- All staff we spoke with knew how to report incidents and record them in the electronic system. We reviewed incident records against safeguarding referrals and daily care notes which confirmed this judgement. Managers shared lessons learned from incidents within teams to prevent future occurrence of the same incident.
- Compliance with safeguarding training was 86% on Allitsen ward. All staff we spoke with understood what constituted a safeguarding concern.
- Staffing levels meant enhanced observations had been carried out safely.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Requires Improvement 	Prior to this inspection we received 2 safeguarding concerns, 2 whistleblowing accounts and 1 injury notification. The safeguarding concerns were in relation to staff lack of knowledge to carry out tube feeding for one patient, staff allegedly not having sufficient information about a patient when handing over to an ambulance crew. One whistleblowing concern was in relation to a concern about low staffing levels affecting patient care and a second about staff knowledge of a patient when providing a handover to an ambulance crew in an emergency. The injury notification was regarding a delay to a patient receiving an x-ray at the local hospital. In order to review the circumstances around all concerns we reviewed staffing numbers, how staff were trained to provide safe care, and we reviewed the safeguarding practices. We also reviewed how staff documented and knew about how to manage patient risk. We rated this core service based on our findings. Our rating for this service went down. We rated it as requires improvement. • We were not assured that Allitsen ward was compliant with all mandatory training requirements. Specifically, basic life support and safety intervention training (previously MAPPA). Data submitted by the provider was contradicted by that given to us by the nurse manager on the day of inspection. • Leadership on Allitsen was not always visible. We heard how leadership changes in senior staff on the ward had de-stabilised the ward, and some governance processes such as monitoring mandatory training were not always used effectively. • Managers had not ensured that all shifts had the correct number of qualified nurses for the duration of the shift. Although the ward was staffed with the right numbers of staff to keep patients safe. The start of some shifts did not

Summary of findings

always meet the planned numbers. Though gaps were filled during the shift with bank staff which brought staffing levels up to safe numbers.
- Communication processes between the ward staff and the physical healthcare team were not always followed when making referrals for physical healthcare following incidents.

However:

- Staff managed incidents safely. Staffing numbers did not have an impact on the ability to manage incidents. All staff we spoke with on Allitsen ward knew how to report incidents and record them in the electronic system. We reviewed 4 serious incident notifications, which confirmed this judgement. Lessons learned from incidents were shared within teams in order to prevent future occurrence of the same incident.
- Staff managed safeguarding incidents well. We reviewed 2 safeguarding concerns related to patients' physical healthcare and one whistle blowing report relating to short staffing. We saw staff had reported, recorded, escalated and investigated all incidents in line with provider policy. We saw evidence of the providers investigation reports, response letters and a duty of candour letter. All staff we spoke with understood what constituted a safeguarding concern.
- Staff managed patients' physical healthcare well.

Summary of findings

Contents

Summary of this inspection

Background to St Andrews Healthcare Northampton

St Andrew's Healthcare has been registered with CQC since 11 April 2011. The service did not have a registered manager in post at the time of the inspection but does have a nominated individual as required, and a controlled drugs accountable officer. At the time of the inspection, the provider had applied to change its registration with CQC to one location instead of multiple registrations across one site. A new application for a registered manager was in progress at the time of the inspection.

The Neuropsychiatry Service consists of two core services; specialist services for adults with an acquired brain injury (5 wards) and wards for older people with mental health problems (4 wards).

At this inspection, we visited 1 ward in the following core service:

- Specialist service for adults with acquired brain injury: Allitsen ward - a 14 bed ward for men with an acquired brain injury.

We did not visit the other four wards for adults with acquired brain injury, or the four wards for older adults with mental health problems;

The last comprehensive inspection of this core service was in June 2016. The service was rated good overall with a rating of good in each key question.

CQC last inspected the Neuropsychiatry service in May 2017 when we carried out a focused unannounced inspection and looked at the key questions of effective and well led for wards for older people with mental health problems. The overall rating was good, with good across all key questions.

What people who use the service say

We spoke with 4 patients on Allitsen ward.

Three patients told us they felt safe on the ward, and that staff were considerate even when they were busy.

While a fourth patient told us they "felt safe on the ward they but did not trust all the staff. He thought some staff talked about him behind his back because they did not like him". He described one occasion when "he had been restrained forcefully by four staff, who were not very nice to him, and that he felt he had more respect from staff in prison than on this ward".

Although 2 patients told us they felt there were enough staff on the ward and they had seen improvements in staff attitudes and the amount of activity offered to them, 2 other patients told us the ward was often short staffed and sometimes ward activities got cancelled.

However, all patients we spoke with confirmed they did get to go out and while staff sometimes had to rearrange their section 17 leave it was rarely cancelled.

Summary of this inspection

How we carried out this inspection

The inspection team visited one ward between 18 October and 20 October 2022. During the inspection we:

- observed how staff cared for patients;
- reviewed the physical health care of three patients on Allitsen ward.
- spoke with 4 patients who were using the services;
- spoke with 4 staff including nurses and healthcare assistants;
- reviewed 5 patient care records;
- reviewed 3 safeguarding notifications; 8 incident records;
- reviewed 3 patients' records of physical health observation records,
- observed 1 patient and staff interaction on Allitsen ward;
- reviewed documents remotely;
- reviewed a range of policies, procedures and other documents relating to the running of the services.

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

Areas for improvement

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

Action the service MUST take to improve:

Services for people with an acquired brain injury:

- The provider must ensure that systems, processes and leadership are in place to ensure robust oversight of training compliance, ensure the correct number of qualified nurses are on all shifts and communication processes are improved to refer to physical healthcare team out of hours. (Regulation 17(2)(a))
- The provider must ensure that staff receive mandatory training. (Regulation 12(1)(2)(c))
- The provider must ensure there are the correct number of qualified nurses on each shift. (Regulation 12(1)(2)(c))

Action the service SHOULD take to improve:

Services for people with an acquired brain injury:

- The provider should continue to deliver the recruitment and retention plan which has commenced.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Requires Improvement	Insufficient evidence to rate	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Insufficient evidence to rate	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Services for people with acquired brain injury

Safe	Requires Improvement
Effective	Insufficient evidence to rate
Well-led	Requires Improvement

Are Services for people with acquired brain injury safe?

Requires Improvement

Our rating for Safe went down. We rated it as requires improvement.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Prior to this inspection, we received 2 whistleblowing concerns about staffing levels affecting patient care and a second about staff knowledge of a patient when providing a handover to an ambulance crew in an emergency. We had concerns that these incidents were connected to staffing numbers and whether staff could keep patients safe. However, we found that with the exception of 3 night shifts the service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, for each shift, and the ward manager could adjust staffing levels according to the needs of the patients. Established staffing levels were 2.0 whole time equivalent (wte) registered nurses and 5.0wte healthcare assistants per shift day and night.

We reviewed actual staffing rosters for the period 14 August 2022 to 14 October 2022 which showed that at times, the service started with lower-than-expected numbers. However, managers addressed the shortfalls with staff from the previous shift staying on for short periods of time to cover any immediate needs, additional staff brought in during the shift to make up numbers, and ward managers supported the registered nurses.

When there was an unfilled registered nurse shift additional healthcare assistants were brought in to make up the numbers. When this occurred on day shifts the ward manager or nurse in charge was included in numbers. If this occurred on a night shift, a registered nurse from an adjacent ward supported the single registered nurse when needed. This meant that the supporting registered nurse stayed on their own ward but remained in direct radio contact with their colleague and if required they could go to their aid as and when required while leaving their own ward safe.

We did not find any correlation between staffing numbers at these times and increased in number or severity of reported incidents.

Requires Improvement

Services for people with acquired brain injury

Data for the period 19 August 2022 to 19 October 2022 showed that 5 day shifts and 3 night shifts had not met the requirement of 2 registered nurses per shift. While the 5 day shifts were made up with an additional healthcare assistants plus the ward manager or nurse in charge. The night shifts, which had 0.9 wte, 0.1wte and 0.3wte registered nurses respectfully, had an additional 2 healthcare assistants and support from the registered nurses on adjacent wards as previously described.

Prior to the inspection we had received a whistleblowing report that had suggested on one occasion, 3 August 2022 staffing numbers were very low. There was no ward manager and the ward seemed chaotic. We looked at the staffing roster for that day, the incident records for that day, and spoke with staff and patients about general staffing levels on the ward. We found that at the start of the shift, there was 1 registered nurse, and 3 healthcare assistants. The ward manager was off sick. There should have been 2 registered nurses, 6 healthcare support workers and a ward manager. The registered nurse escalated the staffing situation as per provider policy. The staffing roster showed that 2 night staff agreed to stay on until 9.00am, plus 3 healthcare assistants and the support of a ward manager from another ward. By 10.30am the ward was up to safe staffing numbers, there were 2 registered nurses and 6 healthcare assistants with a ward manager supplying cover for this and an adjacent ward.

During the period between 9.00am and about 11.00am we saw the names of the occupational therapists and activity co-ordinator were included in staffing numbers. We also found that there had been 3 incidents between 8.00am and 11.00am, 2 of the incidents were de-escalated with verbal support from staff and 1 had resulted in a restraint and 30-minute period of seclusion. We also reviewed incidents across the ward on other days, and this number of incidents for a similar time period was not unusual. None of the incident records showed that incidents were managed unsafely due to staffing numbers.

A senior manager told us that while Allitsen ward continued to have its challenges the staffing situation had improved in the last few weeks and 7 of the 9 staff we spoke with confirmed that the staffing situation continued to improve. The manager explained that they had recently appointed a new ward manager and recruitment for more registered nurses was ongoing. The manager also told us about the steps the senior leaders of the organisation had taken to improve staffing. This included financial enhancements for staff to support recruitment and retention, the new package of staff benefits coming on board and more efficient ways of managing staff movement and transfers between wards.

Managers limited their use of agency staff and if used, they were usually known to patients and other staff. Staff rosters showed that managers used known on site bank staff instead of agency staff where possible and when needed to make up their numbers.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Patients reports and daily care notes showed that patients had regular one to one session with their named nurse or other nurses of their choosing.

Patients, staff, and daily care notes showed that staff rarely cancelled escorted leave. Though staff sometimes rearranged escorted leave to another time on the same day, and occasionally amended activities.

The service had enough staff on each shift to carry out any physical interventions safely, and when requested the physical healthcare team supported the ward with physical health checks.

Mandatory training

Requires Improvement

Services for people with acquired brain injury

We could not be sure that Allitsen ward was compliant with all the mandatory training courses we looked at.

Prior to this inspection, we received 2 safeguarding concerns, 2 whistleblowing accounts and 1 injury notification. We had concerns that these incidents were connected to staffing numbers and whether staff had been suitably trained to keep patients safe.

Data around training compliance was conflicting. Data provided by the organisation showed that as of 30 September 2022, basic life support compliance was 63% and safety intervention training was 45%. While immediate life support was 86%, and adult safeguarding level 3 was 86%.

However, that provided by the nurse manager on the day showed basic life support was 100%, Safety intervention training was 67% and Immediate life support was 63% the nurse in charge did not have the figure for safeguarding adults level 3.

Managers acknowledged the shortfall in basic life support and safety intervention training, citing the absence of a ward manager overview and staff sickness as potential reasons for the shortfall. Neither did we see any evidence that staff had already booked onto courses and two staff members confirmed they had not had time to update their mandatory training.

We reviewed and tracked through all incidents reported to us prior to this inspection relating to Allitsen ward and saw there was no link between the cause for the notifications and staffing levels or lack of training for staff.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating, and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff took part in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Prior to this inspection, we received 2 safeguarding concerns and 1 injury notification. We initially had concerns that these incidents were connected to how staff assessed patients' risk. However, having tracked through the notifications we found this was not the case and the issues actually related to physical health assessment of risk discussed in the effective part of this report.

We reviewed 5 patients risk assessments and risk management plans, 2 sets of which related to the above notifications. We saw that staff completed mental health assessments for each patient on admission to Allitsen ward.

Staff used a recognised risk assessment tool. The service used (START) short term assessment of risk and treatability, which integrated into the patient's electronic health record. Staff also completed specific risks assessment as required, for example the Historical Risk-20 (HCR–20), which is a 20-item structured clinical guide for the assessment of violence risk.

Staff reviewed and updated risk assessments and risk management plans regularly, including after any incidents and ward rounds.

Requires Improvement

Services for people with acquired brain injury

Management of patient risk

We reviewed a total of 3 notifications we had received prior to this inspection. We reviewed these notifications against patient risk assessments, daily care notes, the electronic incident record and ward round minutes. We spoke with 7 staff on the ward and 4 patients.

Our findings showed that staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. Staff could see patients in all areas of the ward staff followed procedures to minimise risks where they could not easily see patients.

We spoke with 4 patients. Three patients told us they felt safe on the ward while a fourth patient told us that although nothing horrible had happened to them, they did not always trust some of the staff. They were not able to give further example of why they did not trust staff.

Use of restrictive interventions

We found that 45% of staff on Allitsen had completed safety intervention training (previously known as MAPPA). We have reported on this in the mandatory training part of this report.

Staff did however take part in the provider's restrictive interventions reduction programme, which met best practice standards. This included discussion of restrictive intervention as part of supervision and what alternatives could be used instead. Reflective practice sessions took place with colleagues in the multi-disciplinary team as well as identifying least restrictive practice options as part of ongoing risk management planning at ward rounds.

A review of incident records, and daily care notes and discussion with staff and patients showed that staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Prior to this inspection, we received 2 safeguarding concerns, 2 whistleblowing accounts and 1 injury notification. Therefore, at this inspection, we reviewed whether staff managed safeguarding practices effectively in this service.

We reviewed the 2 safeguarding concerns received by CQC in August and September 2022. We found that staff had documented all the notifications, investigated, and taken prompt disciplinary action where required. We saw that managers shared lessons learned with the wider team.

Staff received training on how to recognise and report abuse, appropriate for their role. 86% of staff had completed safeguarding adults and children training level 3, and 80% had received safeguarding children and young people level 2. Training records showed that staff kept up to date with their safeguarding training. The provider explained that within St Andrews Healthcare safeguarding adults and children training is combined. Level 2 training is called L2 Safeguarding Children, Young People and Adults and although their level 3 training is called Safeguarding it has been aligned to meet

the expectations set within the Adult, and Children's intercollegiate guidance documents. All clinically registered staff within St Andrews have to attend L3 safeguarding training as a mandatory requirement. Safeguarding Level 3 training consists E-Learning followed by face-to-face training, facilitated by the Safeguarding team and L&D staff. The training is completed every 3 years in line with the Intercollegiate documents for adults and children.

The social work team had oversight of all child visits and facilitated these where needed.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Track record on safety

Reporting incidents and learning from when things go wrong

The service had a good track record on safety. The service reported, recorded, and investigated incidents following regulation and provider policy and managed patient safety incidents well.

Prior to this inspection, we received 2 safeguarding concerns, 2 whistleblowing accounts and 1 injury notification. We had concerns that these incidents were connected to staffing numbers and whether staff could keep patients safe.

We tracked the notifications against the electronic incident record, daily care notes, and safeguarding referrals. We saw the provider had carried out thorough investigations for the incidents reported to us. One was upheld and 1 was not upheld. The details of these incidents have been reported on in the effective key question, under management of physical healthcare.

All staff we spoke with knew how to report incidents and record them in the electronic system. A review of a further 4 incidents picked at random from the provider electronic records supported our judgement. We tracked incidents against the involved patients daily care notes, safeguarding referrals and speaking with staff and patients.

We saw how incidents were categorised against provider policy, and how managers had investigated serious incidents and written up those findings in investigation reports and identified lessons learned.

Staff understood the duty of candour. We saw evidence of 2 duty of candour letters to patients and their families. The letters were open and transparent and gave patients and families a full explanation when things went wrong including offering an apology.

Managers debriefed and supported staff after any serious incident. Staff and patients confirmed this happened.

Staff met in weekly clinical governance meetings to discuss the themes and investigation outcomes. Managers shared the lessons with staff across the site at handovers, team meetings and through internal email.

Are Services for people with acquired brain injury effective?

Requires Improvement

Services for people with acquired brain injury

Insufficient evidence to rate

Assessment of needs and planning of care

Staff assessed the physical health of all patients on admission.

Prior to this inspection we received 2 safeguarding notifications of incidents where allegations had been made that staff did not effectively manage the physical healthcare of 2 patients. We were concerned that staff did not effectively care for the physical health needs of patients.

We reviewed the notifications received by CQC in August and September 2022. We also looked into an allegation of concern raised by a patient during our inspection.

One allegation related to the tube feeding system of a patient; the second was an allegation that staff did not provide a detailed hand over to ambulance staff who were called to deal with a physical health emergency; a third was an allegation of a delay in a patient receiving an x-ray.

We reviewed all care notes, care plans incident records and all investigations completed by the provider in respect of all 3 incidents. In the first incident, it was alleged a staff member did not know how to use the feeding system for a patient in their care. We found detailed care plans on feeding, swallowing and positioning. The allegation was upheld, and the provider took disciplinary action against the staff member who subsequently resigned. The patient came to no harm, and the provider identified lessons learned from the incident. The local authority also completed an investigation and shared learning with the provider. As a result, the physical healthcare team provided training to staff who are required to manage patients with feeding systems and complete regular monitoring of patients who have tube feeding requirements.

The second incident investigation we reviewed, was an allegation that a member of staff did not provide the correct information in a timely manner about the patients' allergies to ambulance staff who were called to deal with a medical emergency. The allegation was not upheld, and the provider's investigation supported the actions of the staff who used the patients' medical notes to answer questions for the ambulance staff.

The third incident we reviewed was an allegation that there was a delay to a patient receiving an x-ray at the local hospital. We saw how the allegation was upheld and duty of candour was honoured. We reviewed the incident record, medical records, daily care notes and the investigation report carried out by the provider. This showed that there had been a 5-day delay between injury occurring and x-rays taken. Staff had relied on patient self-report and personal choice before persuading the patient to attend a local hospital. We saw how the provider had reported and investigated the incident as a serious incident of omission. Managers had identified root cause and put in place lessons learned to prevent a similar thing happening again. Lessons learned included enhanced body map training for all staff, training for all staff in post falls procedures, revised escalation procedures following any injurious incident including ensuring that all post injurious incidents are followed up by a staff member qualified to carry out full physical health assessment. We saw an action plan evidencing how the lessons learned were carried through and the duty of candour letter to the patient apologising for the delay.

Requires Improvement

Services for people with acquired brain injury

We saw that all patients had physical healthcare checks on admission. The receiving team including the responsible clinician completed the initial physical healthcare checks and specialist physical healthcare team followed up with more in-depth checks.

Staff carried out routine daily checks such as blood pressure, temperature and pulse. However, 2 staff told us that while it was normal practice to send a physical healthcare alert to the physical healthcare team after any incident of potential physical harm to patients, this did not always happen, and it depended on the staff on the ward at the time. Therefore in this instance, staff had not followed the reporting system effectively for referring patients to physical health care.

Are Services for people with acquired brain injury well-led?

Requires Improvement

Our rating for well led went down. We rated it as requires improvement.

Leadership

Leadership was not always visible. We heard how leadership changes on the ward had de-stabilised the ward, and some governance processes such as checking mandatory training were not always used effectively.

Two staff members told us that managers had changed so frequently and several staff had left Allitsen ward to work on other wards. This meant that continuity on the ward was difficult to maintain and shifts had not always been as organised as they might be.

One staff member told us the ward had become de-stabilised and not as cohesive as it used to be, and leaders were not visible on the wards either in the daytime or evenings. One staff member told us that managers were not always rebooking staff on mandatory training courses.

Culture

Staff felt respected, supported, and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us they felt able to raise concerns. A system was in place where staff could raise concerns, through the St Andrews safe call system. We heard that this service now had a freedom to speak up guardian, this is someone who can provide an alternative route to speak to the ward manager or other supervisors. Their role was independent and impartial and available for all staff to use.

The service shared key messages which prevented a closed culture. (Closed cultures are when there is poor culture that can lead to harm, where patients may be at risk of potential, deliberate or unintentional harm including human rights breaches such as abuse) from happening. The service did this through several learning interventions, which started with induction of new staff, through to refresher training.

Requires Improvement

Services for people with acquired brain injury

The ward had a care awards initiative to celebrate success and improve the quality of care across the organisations four core values, accountability, compassion, respect, and excellence. The provider presented this award monthly to nominated staff across the division.

Governance

Our findings from the other key questions showed that governance processes did not always run effectively at team level. However, we saw that managers managed performance and risk well.

Whilst the service had systems in place to monitor performance such as dashboard and clinical governance meetings. We found shortfalls in mandatory training compliance and the processes for referring patients to physical healthcare following incidents were not always followed. We understood that these issues had arisen due to frequent leadership changes in the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that all staff had completed mandatory training requirements and the data provided by the nurse manager at inspection did not match the data sent to us by the provider. The provider had not ensured that all shifts had the correct number of qualified nurses for the duration of the shift.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Leadership on Allitsen was not always visible. We heard how leadership changes in senior staff on the ward had de-stabilised the ward, and some governance processes such as monitoring mandatory training were not always used effectively. • Communication processes between the ward staff and the physical healthcare team were not always followed when making referrals for physical healthcare following incidents.