Jeesal Cawston Park

Quality Report

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

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.

Summary of findings

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

Overall summary

We rated Jeesal Cawston Park as requires improvement because:

Staff did not ensure that patients in seclusion were having the required medical and nursing reviews to meet the standards outlined in the Mental Health Act (1993) Code of Practice (2008).

Staff did not ensure that the recording of seclusion was complete and accurate. Managers did not have sufficient oversight of seclusion and restraint recording, despite seclusion recording being identified at a previous focused inspection and in the hospital's own internal audit.

The seclusion room did not meet all the required standards of the Mental Health Act (1993) Code of Practice (2008).

Staff did not consistently and accurately fully record incidents involving restraint and the management of violence and aggression.Staff did not ensure that all patients in long term segregation were reviewed by an approved clinician every 24 hours and that all paperwork relating to long term seclusion was in place.

Staff did not ensure consistent recording of Section 17 leave for patients including risk assessment, clothing notes and details of patient engagement and behaviour whilst on leave.

However:

Staff knew the patients well and we observed good interactions across the hospital, with staff supporting and engaging with patients in a positive manner. Patients we spoke with told us they were happy at the hospital and the staff cared for them well.

There was a wide range of activities available for patients. Activity staff were enthusiastic about their role and told us that activities were person-centred and planned for patients on an individual basis, considering their preferences and interests.

Patients had comprehensive care plans that were holistic, patient focused and included a pen picture, observation and engagement plans, and goals for improving quality of life.

We observed a positive culture and good staff morale during the inspection. Staff we spoke with told us there was good teamwork and they felt respected and supported by managers and colleagues.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	**Requires improvement** 	We rated this service as requires improvement

Summary of findings

Contents

Requires improvement

Jeesal Cawston Park

Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Jeesal Cawston Park

Jeesal Cawston Park provides a range of assessment, treatment and rehabilitation services for adults with learning disabilities and autistic spectrum disorder. The patients receiving care and treatment in this service have complex needs, associated with mental health problems and present with behaviours that may challenge.

The service is registered with CQC for the assessment or medical treatment for persons detained under the Mental Health Act 1983, and the treatment of disease, disorder and injury.

There were 57 registered beds. As part of our inspection we inspected all six wards:

• The Grange – a 15 bedded locked ward accepting male patients only

• The Lodge – a 14 bedded locked ward accepting both male and female patients

• The Manor – a 16 bedded ward which accepted both male and female patients

• The Manor Flats – has six individual living flats, where patients were supported to live independently

• The Manor Lodge – has three self-contained flats, where patients were supported to live independently

• The Yew Lodge - has three self-contained flats, where patients were supported to live independently.

There was a registered manager and a controlled drugs accountable officer in place.

There were 46 patients in the hospital when we inspected. No patients were informal, nine were subject to Deprivation of Liberty Safeguards (where a person's freedom is restricted in their own interests to ensure they receive essential care and treatment) and 37 were detained under a section of the Mental Health Act.

The Care Quality Commission had carried out a focused inspection on 12 and 13 November 2018. This inspection focused on the safe and effective domains and we issued requirement notices for breaches of the following regulations:

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

Regulation 18 HSCA 2008 (Registration) Regulations 2009 Notification of other incidents.

Following the issuing of the requirement notices the provider sent us an action plan outlining the changes they had made to ensure that they met the regulations. At this inspection we found that this service had fully met and addressed actions from our previous inspection in November 2018 relating to the following regulations:

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment.

Regulation 18 HSCA (RA) Regulations 2014 Staffing.

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

However the provider had only partially met actions relating to the following requirement notice as there had not been sufficient improvement in the standard of seclusion recording.

Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment.

Our inspection team

Team leader: Jo Wilson – CQC Inspector

Summary of this inspection

The team that inspected the service comprised eight CQC inspectors and one specialist nurse advisor who had experience of working with people with learning difficulties and autism.

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 six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with three carers or family members of patients
- spoke with the registered manager and managers for each of the wards
- spoke with 21 other staff members; including doctors, nurses, occupational therapist, assistant psychologist, speech and language therapist and staff from the educational skills development team
- attended and observed a multi-disciplinary team progress review meeting for two patients and a daily management team meeting
- Looked at 12 care and treatment records of patients
- carried out a specific check of the clinic rooms and medication management on all wards
- looked at a range of policies, procedures and other documents relating to the running of the service and
- Spoke with NHS clinical commissioning staff, other external stakeholders and attended a quality and performance meeting.

What people who use the service say

- Patients told us they felt safe and well cared for and they were happy at the hospital.
- Patients told us they liked their rooms, which they could personalise by having their own possessions and choosing paint colours and artwork if they wished.
- Patients enjoyed the activities that were available to them including cooking, art, horticulture and sports activities. They were able to suggest ideas for new activities such as bowling.
- Patients told us that they knew how to complain if they were not happy about an aspect of their care or had a concern and staff supported them with this.
- One patient told us that they did not always feel safe at night from having things thrown at them by another patient.
- Two carers told us that they would like more communication from staff about their relative's care.

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:

- Staff did not ensure that patients in seclusion were having the required medical and nursing reviews to meet the standards outlined in the Mental Health Act (1993) Code of Practice (2008).
- Staff did not ensure that the recording of seclusion was complete and accurate and met the standards outlined in the Code of Practice.
- The seclusion room did not meet all the required standards of the Mental Health Act (1993) Code of Practice (2008)
- Staff did not consistently and accurately fully record incidents involving restraint and the management of violence and aggression. A complete record is needed to ensure managers have full oversight of the antecedents to the incident and to ensure appropriate action was taken both during and after the incident to ensure patient safety.
- Staff did not ensure consistent recording of Section 17 leave for patients including risk assessment, clothing notes and details of patient engagement and behaviour whilst on leave.

However

- Care and treatment records showed that staff had completed and updated comprehensive risk assessments. Risk assessments were reviewed regularly, and risk was discussed at the daily management meeting after every incident and patients records updated accordingly.
- Medicines including controlled drugs, emergency medicines and medical gases were stored securely. Equipment such as blood monitoring machines were checked and calibrated appropriately. Staff monitored the temperatures of medicine storage fridges. Medicines were disposed of appropriately.
- Most ward areas were clean and tidy and overall cleanliness had improved since the last inspection. Clinic rooms were clean, well-organised and fully equipped to enable staff to prepare medications and undertake physical health monitoring effectively and safely

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Patients had comprehensive care plans that were holistic, patient focused and included a pen picture, observation and engagement plans, and goals for improving quality of life. Patients displaying challenging behaviour had positive behaviour support plans.
- Staff completed physical health examinations on admission and patients physical health was monitored regularly.
- Staff worked as part of a multi-disciplinary team, which included doctors, nurses, support workers, occupational therapists, speech and language therapists, social worker, assistant psychologists and members of the educational skills development team.
- Staff had regular managerial supervision. As of November 2018, the hospital reported that 100% of supervisions were in date and staff told us that supervision happened regularly and was supportive.

However

- We could not see evidence of regular assessment and recording of mental capacity in patient care notes.

Are services caring?

Good

We rated caring as good because:

- Staff knew the patients well and we observed good interactions across the site, with staff supporting and engaging with patients in a positive manner. We observed staff discussing patients in management and review meetings with care and respect.
- All the patients we spoke with told us they were happy at the hospital and staff cared for them well. One patient told us it was the best hospital he had been in.
- Staff enabled patients to give feedback on the service they received via patient experience surveys, at the Person-Centred Care Programme Guiding Council and 'Our Voice' meetings that are facilitated by independent advocates. Some patients have also participated in staff recruitment interviews.

However

- Two patients told us that they did not always feel safe at night because other patients could be aggressive towards them.
- The provider did not offer specific support for carers, such as targeted information, family therapy or carers/family support groups.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- There was a full range of rooms available at the hospital, including clinic rooms, an activity centre, classrooms, gymnasium, art therapy and woodwork rooms. On The Lodge, patients had a separate kitchen where they could participate in supervised cooking activities.
- Patients were able to personalise their bedrooms, including choosing paint colours, and we saw evidence of this throughout the inspection. Most patients had personal possessions in their rooms and these were individual to each person's wants and needs.
- Activity staff were enthusiastic about their role and told us that activities were person-centred and planned for patients on an individual basis, considering their preferences and interests.
- Staff provided patients with information on how to make a complaint and those patients interviewed stated they knew how to make a complaint. Independent advocates were available to assist patients with making complaints if required.

However:

- There were more limited activities at weekends and a concern was raised by an external stakeholder that patients appeared bored at times at weekends.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Managers had not ensured that seclusion recording was completed to a satisfactory standard with adherence to the Mental Health Act Code of Practice. This was a requirement notice from the last focused inspection in November 2018 and although the hospital recorded actions in this area as complete or ongoing, we could not see sufficient evidence of improvement.
- We observed inconsistency in the recording of incidents, particularly relating to the management of violence and aggression and restraint. Managers had not ensured that staff across all wards were providing full details of incidents, correct recording of restraint positions and physical observations.

However:

- Managers were highly visible in the service and approachable for patients and staff. All the staff we talked with spoke highly of their managers and that they felt well supported. Staff felt that managers understood the challenges that they faced.
- Staff could describe fundamental core values that described their commitment to providing person centred care. Staff knew the vision of the organisation.

Summary of this inspection

- We observed a positive culture and good staff morale during the inspection. All the staff we spoke with told us there was good teamwork and they felt respected and supported by managers and colleagues. Staff were proud to work at Jeesal Cawston Park hospital.
- Staff spoken with felt able to raise concerns without fear of retribution and were aware of the whistleblowing process.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- The hospital reported that as of December 2018, 78% of staff had completed mandatory training in the Mental Health Act.
- The hospital had a Mental Health Act administrator who carried out audits on Mental Health Act papers to ensure detention was legal. We reviewed a random sample of 11 sets of papers relating to patients who were detained under the Mental Health Act. The Mental Health Act administrator had found one set of papers to be invalid during a routine audit and took immediate legal advice. The responsible clinician was informed and detained the patient under section 5(2). The Mental Health Act assessment was carried out within 72 hours and the patient was detained under section 3.
- The Mental Health Act administrator had obtained or was in the process of obtaining, approved mental health professional (AMHP) reports for section 3 patients, where these had been identified as missing in an internal audit. For patients detained under Section 37/41, Ministry of Justice authorisations for transfers were in the patient's file.
- We found an error on a renewal of authority for detention form which was not identified during the provider's scrutiny process. The Mental Health Act administrator sought legal advice and found the detention to be invalid. The consultant psychiatrist detained the patient under section 5(2) and the MHA administrator was to arrange a Mental Health Act assessment. Under duty of candour, the Mental Health Act administrator planned to inform the patient and carers of this error.
- An advocacy service was available for patients. Advocates attended the ward on a weekly basis and were available to give support and advice to patients and their families, including support with Mental Health Act tribunals and making complaints.
- Patients' rights were explained on admission and rights were explained on a regular basis thereafter. Staff used easy read material to help explain these to patients. However, one member of staff told us that she did not explain rights to one patient as she did not believe he had the capacity to understand them, without any exploration if there was an alternative way of communicating this information.

Mental Capacity Act and Deprivation of Liberty Safeguards

- At the time of the inspection, 97% of staff had completed up to date training in the Mental Capacity Act.
- There were six deprivation of liberty safeguards (DoLS) applications in the last 12 months to protect people without capacity to make decisions about their own care. DoLS applications were stored in the electronic patient record system which all staff had access to. We checked DoLS paperwork relating to six patients and found five sets of paperwork were complete. One set of paperwork had a form missing. This was followed up and corrected during the inspection.
- Patient's mental capacity was assessed on admission and capacity to consent to medication was included on medication charts. However, we could not see evidence of ongoing assessments of mental capacity in patient care notes.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- There were numerous blind spots and points that could be used to self-ligature throughout the hospital. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature risk assessments had been improved since the last inspection and included an action plan, with target completion dates, of how these risks were to be reduced, for example replacing door and window handles with anti-ligature fittings. Additional ligature points had been identified on each ward and in the outside areas.
- Staff used their good knowledge of patients, individual risk assessments and zonal observations to mitigate risks, including ligature risks. The Lodge and The Grange are more secure environments and, on these wards, convex mirrors and CCTV are used throughout communal areas to enhance patient safety.
- The seclusion room on The Lodge met most of the required standards as outlined in the Mental Health Act (1983) Code of Practice (2008). A new parabolic mirror to aid observations had been installed and the intercom had been replaced, both of which were actions from the last inspection. However, non anti-pick sealant around the glass in the window, and raised screw coverings behind the toilet could create a potential hazard for patients. The lighting was externally controlled, however there was no subdued lighting suitable for night-time. The seclusion room on The Grange was closed for refurbishment during the inspection visit.
- All of the wards complied with the Department of Health's guidelines on mixed sex accommodation, including provision of a female only lounge on The Lodge and The Manor.
- The main clinic rooms were visibly clean, tidy and fully equipped to enable staff to prepare medications and undertake physical health monitoring effectively and safely. The clinic room at Yew Lodge was very small and staff used the larger clinic room at The Manor for tasks that required more space. Staff monitored and recorded the fridge and clinic room temperatures daily. Emergency grab bags containing resuscitation equipment had the appropriate content and had all the correct checks recorded for the three months prior to inspection.
- The medication hatch on The Lodge, which was a concern at the last inspection because it was large enough for a patient to get through, had been replaced. During the inspection, we observed work also being undertaken to improve the security of the door in The Grange clinic room.
- Most ward areas were clean and tidy and overall cleanliness had improved since the last inspection. However, the communal floor area in the Manor flats was not as clean, and one patient bedroom we viewed here had a dirty floor and stained curtains and soft furnishings. We bought this to the attention of a manager who explained that housekeeping staff were scheduled to clean that area later in the day and there would be follow up regarding replacement of soft furnishings. One patient complained that there could be

an unpleasant smell from the drainage system at The Manor. This was also mentioned at a patient feedback meeting and was observed in a bathroom area during the inspection. This had been under investigation by the hospital since May 2018.

- Kitchens were clean, and we found no out of date food in the fridges. All opened food had been labelled with date of opening.
- Staff carried alarms and/or radios to summon help when needed and these were kept charged regularly. Patients had access to nurse call buttons in all bedrooms and some communal areas, and could approach staff if needing assistance.

Safe staffing

- The hospital used a safe staffing tool based on: Context of Care Tool - Learning Disability Services University of West London. The staffing ratio for day shifts was one staff member for every two patients plus extra requirements for patients on enhanced observations. For night shifts, the ratio was one staff member for every three patients plus extra for enhanced observations.
- All ward managers and three members of nursing staff told us that staffing had improved recently, due to successful recruitment and a slight decrease in patient numbers. Staff told us that most days the hospital had sufficient staff to meet the required staffing ratios and ensure that patients can participate in activities and go out on section 17 leave as planned. Three members of nursing staff told us there were still staff shortages, particularly at nights and weekends on some occasions.
- Managers held a weekly planning meeting, including a review of activities planned for that week. Where staff shortages were identified, qualified or support staff could be moved across wards to ensure adequate cover across the hospital. Staff we spoke with felt this worked well and were happy to support colleagues in this way. Managers also tried to think creatively, for example asking a member of staff to take two patients, rather than one, out on a trip where appropriate.
- The hospital had been actively working on recruitment and were funding four support workers to complete nurse training via the Open University. The hospital had reviewed pay scales and were offering incentive schemes to increase recruitment and retention. Staff were offered overtime to cover unfilled shifts. However, the hospital still had vacancies for registered nurses which remained an area of concern and had been escalated up to the corporate risk register and was reviewed with commissioners through Care Quality review meetings and the hospital Clinical Governance group.
- Managers used bank and agency staff to cover periods where there was staff sickness, a higher number of patients on increased observations and at some weekends. Managers booked regular bank staff as much as possible and these staff were familiar with the hospital, received an induction to the hospital and carried a caseload. When agency staff were used for 2-1 observations, they would always be paired with a permanent member of staff.
- There was always at least one registered nurse on each shift. If patients needs changed, the nurse in charge had the authority to increase observation levels if need be, but observation levels could not be decreased without authorisation from the responsible clinician.
- We reviewed staffing levels for the two weeks prior to inspection. On The Lodge, we saw evidence of unfilled shifts on four occasions within that two weeks, however activities still went ahead for patients. On The Grange we saw evidence of unfilled shifts on two occasions which had an impact on patient activities. For one patient, their one to one staffing for activities was reduced to intermittent observations which meant the patient did not receive the prescribed care as per their care plan. Two patients missed an activity; one patient had this re-arranged, however the other patient did not.
- Where there were unfilled shifts, staff did not always get their scheduled breaks. Managers and staff told us that when this happened, they could get a free meal and time back in lieu.
- Hospital training records across the site for October to December 2018 showed a compliance rate of above 92% for the majority of mandatory training. However, compliance for Mental Health Awareness and the Mental Health Act were lower at 72% and 78% respectively.

Assessing and managing risk to patients and staff

- Between 1 November 2018 and 31 January 2019, there were 29 occasions where staff had placed patients in seclusion at the hospital. The reasons for seclusion met the recommendations of the Mental Health Act (1983) Code of Practice (2008) and the records showed staff attempted other interventions before secluding patients.

Requires improvement

Wards for people with learning disabilities or autism

- We remain concerned that the recording of seclusion was not complete and accurate and did not meet the standards outlined in the Code of Practice. This was an issue raised at the last focused inspection in November 2018 and was noted as an ongoing action in the resultant hospital action plan.
- In eight out of nine applicable records the patient was not seen by a doctor within the first hour. In four of those records doctors had 'authorised' seclusion over the telephone without seeing the patient. The Code of Practice states the person authorising seclusion should have seen the patient immediately prior to commencing seclusion. In five out of seven applicable records there was no evidence of reviews by two registered nurses every two hours. Two out of two applicable records did not have any medical reviews.
- Staff stated all patients in seclusion were observed at all times. There was no way to corroborate this through the records. Three records did not demonstrate 15-minute reports by the staff observing. Some of the 15-minute reviews written up by support workers indicated there was a nurse present but the nurse was not named and there was no assessment or record of the patient's condition and recommendations recorded by the nurse. There was a lack of clarity about the timings of some reviews because records showed the time they were entered on the provider's electronic patient information system, not the time the reviews were undertaken. These issues make it difficult for managers to have an accurate oversight that observations are being completed correctly.
- All 11 records contained the date and time the seclusion ended. However, six of the 11 records did not clearly state the details of the person – name and role - who determined the seclusion should end. When a nurse terminated the seclusion there were no records to evidence they had consulted a duty doctor or responsible clinician. The registered manager confirmed that patients did not have specific seclusion care plans.
- Three patients were in long-term segregation at the hospital. We were unable to locate any records to evidence the decision-making process or who was involved. The ward manager and the consultant psychiatrist said there was a specific form and these had been completed but no-one could find one for any of the patients. Patients' carers were aware of the long term segregation but we could not find any evidence they were involved at the time the decision was made. All patients had contact with an independent mental health advocate.
- One patient in long term segregation had two recent periods of staying for short periods in the seclusion room. As this was a planned intervention whilst maintenance work was carried out in the patient's area, staff were not clear that this was not an appropriate use of seclusion and therefore unclear about what records/ reviews were necessary.
- The Code of Practice states that all patients in long term segregation should be reviewed by an approved clinician every 24 hours. This review was not currently in place since it had been removed as an agenda item from the daily management team meetings. We spoke to the medical director regarding this during the inspection and he advised that this agenda item would be re-instated with immediate effect.
- One patient's care plan focused on long term segregation as a way of managing self-injurious behaviour. The initial review stated the goal of long term segregation was to reduce self-harm, which is not in line with the Code of Practice. We discussed this with the consultant psychiatrist during the inspection who was clear that segregation should not be used for any other reason than harm to others. However, the provider's long term segregation policy does not reflect best practice, as it gives self-harm as one of the reasons for this commencing and one of the staff nurses we talked to said the segregation was more because of self-harm. Subsequent reviews have indicated the patient does assault staff and was likely to cause injury to other patients.
- Risk reduction plans and physical health recording were in place for all patients in long term segregation. Staff demonstrated good knowledge and care of patients and one patient was being supported to increase the amount of time they spent in communal areas on two-to-one observations.
- Between 1 October 2018 and 31 December 2018 there was a total of 743 incidents of the use of restraint across the hospital. As part of their quality and safety governance, the hospital has identified two patients as having a significant contribution to the number of restraints. One of these patients was a new admission and the other a patient currently supported in long term segregation who had a significant behavioural

deterioration in December. Staff reported that where possible they used de-escalation techniques and only used restraint with patients as a last resort when other techniques had failed. The hospital has a 10 point strategic action plan for reducing restrictive practices including specific action in the area of personal behaviour support (PBS).

- The Mental Health Act (1993) Code of Practice (2008) recommends that the use of prone (face down) restraint is not used apart from in exceptional circumstances, due to the risks to patients of compression to the chest and airway. The hospital states that the use of prone restraint is discouraged and only used for administering intravenous medication, or where care-planned as a therapeutic hold, and in those cases the patient is turned into supine position as soon as possible. Between 1 October and 31 December 2018, there were a total of 24 occasions where staff restrained patients in a prone position. The hospital reported that all incidents of prone restraint occurred on The Lodge and 17 of these incidences involved one patient.
- We spoke with the instructor who teaches restraint who confirmed that the use of prone restraint was taught to staff but for the purposes stated above only. Staff were not taught alternative techniques for the administration of intravenous medication. She confirmed that she reviews the paperwork relating to prone restraint to ensure it is appropriate and recorded correctly. There were two records of prone restraint that did not have a stated rationale for use. The instructor was aware of these incidents. One noted prone restraint occurred when a patient threw themselves forward from a standing position and staff followed them to the floor for safety reasons.
- There was inconsistent recording of the management of violence and aggression, including the use of restraint. One member of staff who had an overview of this area told us that staff completed records in an inconsistent manner and did not always record what had happened leading up to the incident. We reviewed recording on The Lodge and The Manor. On The Lodge we reviewed records relating to three incidents and found that these were completed well with a full description of the incident that led to restraint, restraint positions used, body maps detailing any injuries and physical observations recorded or a note made if the patient refused. However, on The Manor, only brief and incomplete descriptions were given in the four records reviewed and positions were recorded incorrectly. There was also incomplete documentation relating to physical observations taken.
- The hospital undertook its own clinical audit on the standard of recording of restraint and produced a report in June 2018. The report concluded that the hospital had not reached its target of 100% error free reporting. It was reported that 73% of restraint forms sampled accurately reported the type of physical intervention and people involved in the restraint. Only 64% reported the use of physical intervention using the correct terminology.
- Twelve care and treatment records showed that staff had completed and updated comprehensive risk assessments from the time of admission. Patient risk was assessed across 14 domains, including risk of self-harm, risk to others and risk of damaging property. Risk assessments were reviewed regularly, and risk was discussed at the daily management meeting after every incident and the patients records updated accordingly.
- We looked at Section 17 leave information in four patient records. Section 17 leave for patients was authorised correctly. However, the recording of Section 17 leave was inconsistent. Staff had not consistently recorded risk assessment prior to patients taking Section 17 leave in care notes. Staff had not consistently recorded patient clothing checks and information about patient behaviour and engagement while on leave.
- There were no blanket restrictions in place. Any patient needing restrictions would be individually risk assessed. This was confirmed by the records reviewed and with discussions with patients.
- The hospital has an up to date observation and engagement policy which sets out the principles and procedures when patients require enhanced observations and the role of the observing staff. From reviewing staffing figures, we could see that most days staffing was sufficient over the two weeks prior to the inspection to cover the level of enhanced observations required. However, on days when there were not the desired number of staff, it was not clear how staff would have got appropriate breaks needed.
- We looked at 12 patient care plans and in all of them observation levels were reflected both in the care plan and in progress note entries. Staff we spoke with were aware of the observation and engagement policy and had good knowledge of individual patient risks.

Requires improvement

Wards for people with learning disabilities or autism

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. The provider's patient safety and quality report for the period 1 October 2018 to 31 December 2018 reported that 99% of eligible staff had received safeguarding training.
- Between 1 October 2018 and 31 December 2018, a total of 66 safeguarding notifications had been made to the local authority. There has been a substantial increase in the number of safeguarding notifications made since the first quarter of the year when there were 24 notifications. 13 of these involved allegations made against staff and the organisation. Norfolk Safeguarding Team have been informed of this and are currently carrying out an investigation to identify the reason for trend.
- An external stakeholder told us that they felt the hospital did not always identify, and proactively consider, the antecedents to behaviour that could lead to a safeguarding referral, e.g. incidences of patient on patient assault.
- Safeguarding notifications were being sent appropriately to CQC, at the time of the incident. However the safeguarding lead at the hospital told us that CQC were notified of a safeguarding issue only when the safeguarding team had advised it was an appropriate referral. We were concerned that there was confusion about this process.

Staff access to essential information

- All staff had access to the electronic patient information system. Staff we spoke with felt this was now working well after some teething problems where information was not correctly recorded on the system and bugs and errors occurred. Staff used portable tablet computers, so they could access and update records in a timely manner whilst working anywhere in the hospital.
- Managers could use the electronic patient information system to send memos to all staff which would pop up on their screens when they logged in and would stay on screen until a box was ticked to say they had read the information. These memos could relate to information about incidents, lessons learnt or a prompt to staff to add more information to a record where they had not included all the relevant details. Staff also used the system to initiate and follow up maintenance requests and to record supervision and appraisal details

Medicines management

- We reviewed 15 prescription charts and found there was effective medicine management. Prescription charts had a photo of the patient to aid with identification for staff not familiar with the patient, and a mental capacity assessment form. Staff stored medicines in accordance with the manufacturers' guidelines. Prescriptions were written in line with British National Formulary guidance and recorded alerts for patient allergies.
- Medicines including controlled drugs, emergency medicines and medical gases were stored securely. Equipment such as blood monitoring machines were checked and calibrated appropriately. Staff monitored the temperatures of medicine storage fridges. Medicines were disposed of appropriately.
- Regular audit was undertaken by the contracted pharmacist and any actions identified were addressed. We viewed the audit and found it to be up to date and complete.

Track record on safety

- The number of reported incidents had increased. Between 1 October and 31 December 2018 there were 2177 incidents across the hospital. This compared to 1946 incidents between 1 July 2018 and 30 September 2018. Of these incidents, 594 occurred on The Lodge. The most common behaviour displayed during these incidents was non-person directed aggression, followed by aggression towards others. The provider reported that the number of incidents had increased due to a number of new admissions to the hospital during this time period, including the admission of one particularly unsettled patient.
- Between 1 December 2017and 30 November 2018, 59 serious incidents were reported via the Strategic Executive Information System. A serious incident is an incident that has resulted in serious physical or emotional injury or damage to property essential to the security and effective running of the unit. The most common type of incident reported was disruptive, aggressive and violent behaviour meeting the criteria for a serious incident.

Requires improvement

Wards for people with learning disabilities or autism

Reporting incidents and learning from when things go wrong

- Staff recorded incidents onto the electronic patient information system. All staff, including agency staff, were provided with portable tablet computers connected directly to this system so they could complete incident reporting immediately after an incident. Senior managers discussed each incident at the morning management meeting and updated patients' care plans and risk assessments accordingly. We observed incident forms being discussed at the daily management meeting and a small number being sent back to staff if they were not completed satisfactorily, before being signed off by a manager or a doctor. The managers also made a note to discuss these with those relevant staff after the meeting to ensure they understood the improvements needed.
- Managers could alert all staff to incidents and lessons learnt by sending a memo via the electronic patient information system. A lessons learnt bulletin was sent to all staff by e-mail. Managers told us they checked staff's understanding and learning from these memos during meetings and supervision sessions. Discussion regarding incidents and lessons learnt took place at shift handovers and during team meetings. Managers told us they were planning to add podcasts to the electronic patient information system about lessons learnt from incidents and a quarterly 'lessons learnt' awayday was being planned.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 12 care and treatment records. Patients had comprehensive care plans that were holistic, patient focused and included a pen picture, observation and engagement plans, and goals for improving quality of life. Patients displaying challenging behaviour had positive behaviour support plans. Care records included a a comprehensive risk assessment which identified and categorised risks across 14 domains. Risks were reviewed regularly and also discussed at the daily management meeting and updated after incidents involving the patient.
- Care records showed that physical health examinations were completed on admission and monitored monthly throughout treatment.

Best practice in treatment and care

- The hospital had appointed a practice nurse to provide physical health care, monitoring and health promotion to patients. Two nurses who had training and an interest in physical health also supported patients with their physical health needs. When patients were reluctant to have physical observations taken, staff worked with them to encourage these or used alternative methods of observation such as monitoring breathing or skin colour. A local GP attended the hospital once a week. Staff were receiving further training in wound management and head injury.
- All new patients had a psychology initial assessment where appropriate. Psychological therapies were offered, as recommended by the National Institute for Health and Care Excellence. The range of interventions included, anger and anxiety, bereavement and emotional and distressed behaviour. These were available for patients on a one to one basis, in groups and with family. Psychologists were involved in writing positive behaviour support plans.
- The hospital used recognised rating scales to assess and record individual patient outcomes. For example, the health of the nation outcome scales for learning disabilities.
- A number of clinical audits had been conducted in the 12 months prior to the inspection. These included, occupational therapy initial assessment, enabling opportunities to communicate with service users and compliance with PRN recording. The hospital has joined the Royal College of Psychiatrists Quality Network for Inpatient Learning Disability Services.

Skilled staff to deliver care

- We reviewed six staff files which showed that staff had the correct pre-employment checks. All new staff were offered one week's pre-induction learning followed by a two-week induction period on the wards, which

included health and safety, the mental health act, safeguarding and the management of violence and aggression. A new member of staff told us that his induction was very organised and effective. Support staff are required to complete the Care Certificate before they complete their probation period.

- Staff had access to appropriate training. Figures provided by the hospital showed that compliance with mandatory training as of December 2018 was above 92% for all courses apart from mental health awareness which had a compliance rate of 72% and mental health act which had a compliance rate of 78%. The low compliance figure of mental health awareness training was raised as a concern at a quality performance and review group meeting in November 2018. This was being addressed by the Director of Training who confirmed this was not included in induction training and they were looking at ways to improve this figure, including buying in Mental Health First Aid training from an external supplier.
- Staff told us they had good opportunities for personal and professional development. The hospital was funding four support workers to complete their nurse training via the Open University. Regular bank staff are offered training, support and supervision and hold a caseload of patients. In the staff survey carried out in November 2018, 87% staff either strongly agreed or agreed that they had access to the learning and training they needed to do their job well. Staff told us that the organisation training department was very good.
- Staff had regular managerial supervision. As of November 2018, the hospital reported that 100% of supervisions were in date and staff told us that supervision happened regularly and was supportive. Staff appraisals were up to date.

Multi-disciplinary and inter-agency team work

- Staff worked as part of a multi-disciplinary team, which included doctors, nurses, support workers, occupational therapists, speech and language therapists, social worker, assistant psychologists and members of the educational skills development team. The post of consultant clinical psychologist is currently vacant, and the hospital was actively recruiting to fill this post. Staff told us there was effective multi-disciplinary working with good, supportive relationships between nursing and therapy staff. Nursing staff told us they felt able to ask medical and therapy staff for support and advice regarding individual patients.
- There were monthly multi-disciplinary team meetings held for each patient to discuss attendance at activities and therapies, incidents, risks, goals and progression towards discharge. The patient, or a representative attended these meetings and were encouraged to share their views and experiences. We observed one meeting and saw staff demonstrating good knowledge of patients and their needs, with the patient at the heart of the discussion.
- Staff described effective working relationships with the local authority and commissioners. All commissioners, through care mangers, are sent monthly reports detailing progress that the patient is making and commissioners attend individual patients' Care Programme Approach Meetings (CPAs) every six months.

Adherence to the MHA and the MHA Code of Practice

- The hospital reported that, as of December 2018, 78% of staff had completed mandatory training in the Mental Health Act. This was lower than compliance with other mandatory training.
- The hospital had a Mental Health Act administrator who carried out audits on Mental Health Act papers to ensure detention was legal. We reviewed a random sample of 11 sets of papers relating to patients who were detained under the Mental Health Act. The Mental Health Act administrator had found one set of papers to be invalid during a routine audit and took immediate legal advice. The responsible clinician was informed and detained the patient under section 5(2). The Mental Health Act assessment was carried out within 72 hours and the patient was detained under section 3.
- The Mental Health Act administrator had obtained, or was in the process of obtaining, approved mental health professional (AMHP) reports for section 3 patients. For patients detained under Section 37/41, Ministry of Justice authorisations for transfers were in the patient's file.
- We found an error on a form H5 (section 20 – renewal of authority for detention) which was not identified during the provider's scrutiny process. The Mental Health Act administrator sought legal advice and found the

detention to be invalid. The consultant psychiatrist detained the patient under section 5(2) and the MHA administrator was to arrange a Mental Health Act assessment. Under duty of candour, the Mental Health Act administrator planned to inform the patient and carers of this error.

- An advocacy service was available for patients. Advocates attended the ward on a weekly basis and were available to give support and advice to patients and their families, including support with Mental Health Act tribunals and making complaints.
- Patients' rights were explained on admission. Their named nurse would then review this; rights were explained on a regular basis thereafter. Staff used easy read material to help explain these to patients. However, one member of staff told us that she did not explain rights to one patient as she did not believe he had the capacity to understand them, without any exploration if there was an alternative way of communicating this information.

Good practice in applying the Mental Capacity Act

- At the time of the inspection, 97% of staff had completed up to date training in the Mental Capacity Act.
- There were six deprivation of liberty safeguards (DoLS) applications in the last 12 months to protect people without capacity to make decisions about their own care. DoLS applications were stored in the electronic patient record system which all staff had access to. We checked DoLS paperwork relating to six patients and found five sets of paperwork were complete. One set of paperwork had a form missing. This was followed up and corrected during the inspection.
- Staff assessed patients mental capacity on admission and medication charts included capacity to consent to treatment. However, there was not evidence of ongoing formal assessments of mental capacity in patient care notes.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff knew the patients well and we observed good interactions across the site, with staff supporting and engaging with patients in a positive manner. We observed staff discussing patients in management and review meetings with care and respect.
- We spoke with 10 patients. All the patients we spoke with told us they were happy at the hospital and the staff cared for them well. One patient told us it was the best hospital they had been in. Eight patients told us they felt safe at the hospital and their possessions were safe. However, two patients told us that they do not always feel safe at night because other patients can be aggressive towards them. One patient had been supported by staff to submit a complaint about this which was being investigated. Despite this, the patient told us they were happy at the hospital and family members were able to visit them regularly.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Involvement in care

- We saw evidence that patients were involved in their care plans and were given copies where appropriate. One patient was able to tell us in detail about his care plan and that he had a copy in his room. In a patient experience survey, administered by an independent advocate in August and September 2018, 76% of patients said they had a copy of their care plan and 82% knew their goals for treatment.
- Patients knew how to access an advocate; they said that staff would help make a referral. We saw information displayed on the televised screen about the advocacy service, their staff, and other services.
- Staff enabled patients to give feedback on the service they received via patient experience surveys, at the

Requires improvement

Wards for people with learning disabilities or autism

Person-Centred Care Programme Guiding Council and 'Our Voice' meetings that are facilitated by independent advocates. Some patients have also participated in staff recruitment interviews.

- Five patients told us that their families visited regularly, and they are able to make phone calls to their families when they wanted to. One staff member told us that they assisted a carer, who travelled a long way to visit, with local accommodation and he was able to eat at the hospital with his son.
- We spoke to three carers. One carer, whose relative had very complex needs, told us that the care given was 'first class'. Two of the carers we spoke with were not satisfied with the level of communication they had from the hospital regarding their relative's progress, although information was given to them if they asked for it. One carer felt that their relative should be encouraged to do more activities during the day rather than being allowed to sleep.
- The hospital did not provide any specific support for carers, such as targeted information, family therapy or carers/family support groups. One member of staff told us they had tried to offer a carer support group in the past, however this did not successfully become established. One carer told us she was invited to care reviews and tribunals but did not feel that her views were always considered. The hospital did not notify carers when a patient was put into seclusion, which is a requirement under the Mental Health Act Code of Practice.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

- Average bed occupancy over the last 12 months was 91%. Five out of six wards had a bed occupancy of more than 93%. The average length of stay for patients was 666 days.
- The hospital accepted patients from all parts of the country. Patients were discharged to suitable placements near home if it was possible. Discharge planning meetings took place where aftercare services were considered. Discharges could be delayed because of the difficulty of finding community placements with some patients who had complex needs.
- Staff gave us examples of when keyworkers had accompanied patients visiting a potential new placement to support them in their new environment and aid transition. Staff could stay with the patient for several days in the new setting, if necessary.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms available at the hospital, including clinic rooms, an activity centre, classrooms, gymnasium, art therapy and woodwork rooms. A patient kitchen was available at The Lodge where supervised cooking activities took place. The hospital is set in spacious, pleasant grounds, so patients were able to access outside areas including a small farm and take part in gardening and horticultural activities.
- The Lodge, Manor and the Grange all had quiet rooms for male and female patients. The hospital provided a dedicated room for visitors off the wards, except for the Manor where there was a dedicated room on the ground floor of the ward building.
- Patients had access to phones and were able to make calls in private; this was throughout all patient areas in the hospital.
- There was a range of food available at meal times. A patient experience survey conducted in August 2018 showed some patients felt the food could be better. One patient told us that they enjoyed the food, but there were too many sandwiches. Patients could make drinks and snacks throughout the day and staff encouraged patients to make healthy choices.
- Patients were able to personalise their bedrooms, including choosing paint colours, and we saw evidence of this throughout the inspection. Most patients had personal possessions in their rooms and they were individual to each person's wants and needs. One patient had painted artwork on the wall, with the

Requires improvement

Wards for people with learning disabilities or autism

support of the art therapist. We observed two bedrooms that were quite bare, with limited possessions. Staff explained that they always offered patients choices regarding the personalisation of their bedrooms.

- Patients interviewed felt their belongings were secure. Patients had safes in their rooms, if appropriate, and the hospital also has a secure storage room for patient's property. One patient told us that some of their clothes had gone missing in the laundry; this was being addressed by the hospital.
- No patient bedroom doors had viewing panes which meant that patients on observations had to have their doors left continuously ajar for staff to observe them. This could have an impact on a patient's privacy and dignity.
- We spoke with the activities and sports co-ordinators and other members of the educational skills development team. There was a wide range of activities available during the week, including trips off site. The hospital had its own minibuses, including a minibus adapted for the needs of one particular patient. Activity staff were enthusiastic about their role and told us that activities were person-centred and planned for patients on an individual basis, with consideration of their preferences and interests. We observed staff engaging positively with a patient during an art session.
- There were more limited activities at weekends and a concern was raised by an external stakeholder that patients appeared bored at times at weekends.

Meeting the needs of all people who use the service

- There were adapted bedrooms in the hospital for patients needing disability support. These rooms had suitable en-suite facilities. The Manor had bedrooms upstairs. There was a lift available for patients in wheelchairs, although this was not currently being used as it was not needed.
- Wards had information leaflets available including in easy read formats, and there was a televised notice board system for information.
- The hospital provided a menu for patients to choose a variety of meals, which met their individual religious and cultural needs.
- Staff told us that all patients had access to spiritual support. We saw an area of the lounge that was suitable for Christian worship and a chaplain visited regularly. Staff told us that if patients from other faiths wanted spiritual support, they would arrange this with community faith groups.

Listening to and learning from concerns and complaints

- The hospital received 34 formal complaints in the last 12 months, one was upheld, 11 were partially upheld and no complaints were referred to the Ombudsman. The hospital investigated complaints and responded to complaints within the appropriate timeframe and apologised when required in line with the Duty of Candour. Complaints are reported monthly to the Board of Directors and on a quarterly basis to a Quality and Performance Review Meeting held with the local clinical commissioning groups.
- Staff provided patients with information on how to make a complaint and those patients interviewed stated they knew how to make a complaint. Independent advocates were available to assist patients with making complaints if required.

Are wards for people with learning disabilities or autism well-led?

Requires improvement

Leadership

- Managers had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Managers were highly visible in the service and approachable for patients and staff. All the staff we talked with spoke highly of their managers and that they felt well supported. Staff felt that managers understood the challenges that they faced.

Vision and strategy

- Staff could describe fundamental core values that described their commitment to providing person centred care. Staff know the vision of the organisation.
- In the November 2018 staff survey, 97% of staff agreed that they understood the company mission statement

Culture

Requires improvement

Wards for people with learning disabilities or autism

- We observed a positive culture and good staff morale during the inspection. All the staff we spoke with told us there was good teamwork and they felt respected and supported by managers and colleagues. Staff were proud to work at Jeesal Cawston Park hospital. Four members of staff told us that the hospital was the best place they had ever worked.
- Staff felt able to raise concerns without fear of retribution and were aware of the whistleblowing process.
- Managers dealt with poor staff performance when needed. Staff felt there were good opportunities for personal and professional development.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. Between November 2017 and December 2018, the average staff sickness rate was 3.3% which is low compared to other providers.
- The results of the staff survey undertaken in November 2018 showed that staff were dissatisfied with some aspects of how information was communicated to them, with too much reliance on technology. Staff also felt they would like more incentives for good performance, such as an employee of the month award.
- Two staff members told us they would like more support following incidents of racial or verbal abuse from patients.

Governance

- Managers had not ensured that seclusion recording was completed to a satisfactory standard with adherence to the Mental Health Act Code of Practice. This was a requirement notice from the last focused inspection in November 2018 and although the hospital recorded actions in this area as complete or ongoing, we could not see sufficient evidence of improvement.
- We observed inconsistency in the recording of incidents, particularly relating to the management of violence and aggression and restraint. Managers had not ensured that staff across all wards were providing full details of incidents, correct recording of restraint positions and physical observations. The hospital had completed its own audit in June 2018 which identified that only 73% of restraint forms were fully accurate and had implemented staff training and further management checks in response. However, during our inspection we observed forms still not completed fully and accurately
- We were concerned that there was a patient identified as being cared for in a single service who would be more appropriately described as being in long term segregation. The patient lived alone in one of the self-contained flats and did not mix with other patients, or the public, at any time due to risk to others. We were satisfied he was being well cared for and this was the most appropriate setting for him. We do not recommend that he is moved from his current setting. However, we were concerned that this was not acknowledged as being long term segregation. This meant we could not be fully assured that all the proper safeguards were in place to ensure effective oversight of his care by external professionals.
- There was a clear framework of what must be discussed at a ward, team or governance level to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Managers were responsive and open to feedback from commissioners, regulators, safeguarding leads and other stakeholders.

Management of risk, issues and performance

- Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.
- Staff concerns matched those on the risk register.
- The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Information management

- Staff had access to the equipment and information technology needed to do their work. After some initial teething problems, staff felt that the patient electronic record system, worked well and helped to improve the quality of care.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Learning, continuous improvement and innovation

Requires improvement

Wards for people with learning disabilities or autism

- The hospital was participating in the Royal College of Psychiatrists quality network for inpatient learning disability services. This standard based quality external accreditation network facilitated good practice across similar services nationally.
- Therapy staff told us they had the opportunity to be involved in research and development and to participate in external conferences. Staff have set up a regional sensory education group to share best practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients in seclusion have the appropriate medical and nursing reviews as outlined in the Mental Health Act (1993) Code of Practice (2008).
- The provider must ensure that the recording of seclusion is completed fully and accurately in accordance with the Mental Health Act (1993) Code of Practice (2008).
- The provider must replace sealant in the seclusion room with anti-pick sealant, cover raised screws and provide subdued lighting for night-time use.
- The provider must ensure that the recording of incidents involving the management of violence and aggression, including the use of restraint, is completed fully, accurately and consistently across the hospital, including details of physical health checks undertaken.
- The provider must ensure that all mental health act paperwork is in order and internal audits are sufficiently thorough so that no errors occur.
- The provider must ensure that all patients in long term segregation are reviewed by an approved clinician every 24 hours and that all paperwork relating to long term segregation is in place.
- The provider must consider where a patient is in a single service if this constitutes long term segregation and assure that all safeguards are in place.
- The provider must ensure consistent recording of Section 17 leave for patients including risk assessment, clothing notes and details of patient engagement and behaviour whilst on leave.

Action the provider SHOULD take to improve

- The provider should ensure that there is sufficient staffing every day, including weekends, to ensure staff have their full breaks and patients are able to do activities as planned.
- The provider should review their use of prone restraint and ensure they have considered all alternative methods in the circumstances where this is currently used.
- The provider should consider all staff having Mental Health Awareness and Mental Health Act training as part of their training.
- The provider should ensure all staff are clear about when a safeguarding notification is made to CQC.
- The provider should ensure that ongoing capacity assessments are carried out on a regular basis and clearly recorded in patients notes.
- The provider should ensure they plan effective engagement and communication with carers, seeking carer feedback wherever possible.
- The provider should, in collaboration with patients, review the options for the installation of viewing panes in doors to ensure patient dignity and privacy.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • **The provider had not ensured that seclusion records were complete and accurate.** • **The provider had not ensured that restraint incidents were accurately recorded or that physical health checks took place after restraint.** • The provider had not ensured that the seclusion room was safe to use for its intended purpose and used in a safe way. • The provider had not ensured consistent recording of Section 17 leave for patients including risk assessment, clothing notes and details of patient engagement and behaviour whilst on leave

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 had not ensured that systems or processes were established and operated effectively to ensure compliance and assess, monitor and improve the quality and safety of the services with relation to the monitoring of seclusion and long term segregation, adherence with the mental health act and the recording of restraint incidents and the management of violence and aggression.**