Baldock Manor

Quality Report

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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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

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

Overall summary

This inspection was carried out to follow up and review action taken by the provider against warning notices issued following an inspection in November 2015.

At this inspection of May 2016 we found:

- Staff had not completed in full or regularly updated eight out of 15 risk assessments.
- Electronic incident reports were not fully completed. Incidents had taken place but staff had not recorded them in patients' case notes or completed incident forms in all cases.
- Staff did not keep up to date records to ensure that they were monitoring incidents, lessons learnt and outcomes. Managers did not review, record actions taken or outcomes for patients on the majority of incident forms.
- There had been 24 safeguarding incidents, of which 18 had not been notified to the CQC. Senior managers did not have robust monitoring systems in place for monitoring the outcomes of safeguarding incidents and to ensure that external agencies were notified in a timely way.

Summary of findings

- Staff and patients had used furniture to prop doors open on all wards across the service. The propping open of doors was in breach of both health and safety, and fire regulations.
- The provider had installed mirrors to mitigate risk where some blind spots had been identified. However, this did not mitigate risk in some areas due to their position.
- We found the emergency bag on Mulberry ward had a pulse oximeter without batteries from 09 September 2015 to 01 May 2016.
- Staff did not have access to the correct clinical waste products and had not followed infection control principles when discarding clinical waste. Staff had not completed handwashing training for 12 months.
- There had been some improvement to staff training. However, only 62% of staff had completed mandatory training and 70% completed refresher training. The provider had an action plan in place to improve compliance with mandatory training.
- Monthly meetings took place to discuss service wide improvements. However, actions identified as required were not all undertaken. It was also not clear that the learning from these meetings was shared across the service.

However:

- The majority of care plans were fully completed and reviewed regularly.
- Staff ensured the patient's physical health was monitored regularly. This included blood tests and electrocardiograms.
- Staff monitored and recorded patients fluid intake when required to ensure they were receiving the recommended daily allowance. The multidisciplinary team and dietitian reviewed fluid charts regularly.
- Staff were not using restrictive practices to manage the risks of the patients.
- Managers completed comprehensive ligature and environmental risk assessments for all wards and these were up to date.
- The hospital was now compliant with guidance on same sex accommodation.
- The provider had systems in place to ensure that agency staff were appropriately trained prior to working with patients.
- Complaints were investigated and outcomes and lesson learnt were shared with the complainant and discussed in monthly meetings.
- Activity rooms were available across the service that were equipped with games and activities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for adults		Inspected but not rated

Summary of findings

Contents

Baldock Manor

Services we looked at

Long stay/rehabilitation mental health wards for adults;

Summary of this inspection

Background to Baldock Manor

Baldock Manor is a private hospital that provides a rehabilitation service to people who have needs related to their mental health and who are either detained under the Mental Health Act 1983, or are voluntarily staying at the hospital.

There were four wards:

• Radley – Learning Disability ward with 10 beds

• Mulberry – Mental Health, male ward with 15 beds

• Burberry – Mental Health, female ward with 9 beds

• Oakley Female and Oakley male – Older People with 15 beds.

At the time of the inspection, there were 36 patients at Baldock Manor.

The Care Quality Commission (CQC) last inspected Baldock Manor in November 2015. The provider had breached regulation 12, 14 and 17 of the Health and Social Care Act and was given an overall rating of inadequate. We concluded that Baldock Manor was no longer in breach of regulation 14, but remained in breach of regulation 12 and regulation 17.

Our inspection team

Team leader: Sarah Duncanson.

The team that inspected Baldock Manor consisted of three Inspection Managers, three Inspectors, one Mental Health Act Reviewer and a Specialist Professional Advisor.

The team would like to thank all those who met and spoke with inspectors during the inspection.

Why we carried out this inspection

We inspected this service in order to check for compliance against warning notices that were served on the provider in January 2016 due to the provider breaching Regulations 12, 14 and 17 of the Health and Social Care Act.

We undertook this inspection to find out whether Baldock Manor had made improvements to their service since our last comprehensive inspection in November 2015.

When we last inspected Baldock Manor in November 2015, we rated the service as inadequate overall. We rated the core service as inadequate for Safe, inadequate for Effective, requires improvement for Caring, inadequate for Responsive and inadequate for Well-led.

Following this inspection we told the service that it **MUST** take the following actions to improve:

- The provider must ensure that blind spots on wards are mitigated.
- The provider must ensure that they comply with Department of Health guidance on same sex guidance.
- The provider must ensure that they have up to date and accurate staff files.
- The provider must ensure that risk assessments are fully completed and reviewed regularly.
- The provider must ensure that seclusion and restrictive intervention are recorded as outlined in the Mental Health Act code of practice.
- The provider must ensure that all medications are stored, dispensed, or administered in line with legislation and guidance.
- The provider must ensure that staff can access emergency equipment quickly when required.
- The provider must ensure lessons learnt and action plans are in place after incidents.

Summary of this inspection

- The provider must ensure that incident reports are fully completed.
- The provider must ensure that the physical healthcare needs of individual patients are monitored and assessed regularly including following up abnormal results.
- The provider must ensure that individual care plans are patient centred and reviewed regularly with patients.
- The provider must ensure that patients receive adequate daily fluids.
- The provider must ensure that staff receive training in the Mental Capacity Act.
- The provider must ensure there are suitable dining arrangement for patients.
- The provider must ensure that the ward environment promotes the comfort and dignity of patients.
- The provider must ensure that their complaints procedure is robust and effective and that outcomes of complaints are shared within the team.
- The provider must ensure they have an effective system in place to monitor and improve the quality of the service.
- The provider must ensure that the results of clinical audits are used to improve services for patients.

Action the provider SHOULD take to improve

- The provider should ensure that all staff are up to date with mandatory training.
- The provider should ensure that systems are in place for effective staff recruitment and retention.

We also issued Baldock Manor with one requirement notice. This related to:

- Bedroom and bathroom arrangements on Oakley Ward did not comply with Department of Health and Mental Health Act Code of Practice guidance on same sex accommodation.

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 responsive to people's needs?
- Is it well-led?

On this inspection, we assessed whether Baldock Manor had made improvements to the specific concerns we identified during our last inspection.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with the hospital manager, ward managers and human resource staff
- Interviewed nine other staff members; including doctors, nurses, and the social worker;
- Looked at 19 care and treatment records of patients:
- carried out a specific check of medication management and physical health monitoring
- Reviewed 51 incident reports and 24 safeguarding incidents.

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?

This inspection was carried out to follow up and review action taken by the provider against warning notices issued following an inspection in November 2015.

At this inspection of May 2016 we found the following issues the service provider needs to improve:

- Staff had not completed in full or regularly updated eight out of 15 risk assessments.
- Electronic incident reports were not fully completed. Incidents had taken place but staff had not recorded them in patients' case notes or completed incident forms in all cases. Senior staff did not keep up to date records to ensure that they were monitoring incidents, including safeguarding incidents, lessons learnt and outcomes. Managers did not review, record actions taken or outcomes for patients on the majority of incident forms.
- There had been 24 safeguarding incidents, of which 18 had not been notified to the CQC.
- Staff and patients had used furniture to prop doors open on all wards across the service. The propping open of doors was in breach of both health and safety, and fire regulations.
- The provider had installed mirrors to mitigate risk where some blind spots had been identified. However, this did not mitigate risk in some areas due to their position.
- We found the emergency bag on Mulberry ward had a pulse oximeter which had been without batteries from 09 September 2015 to 01 May 2016.
- Staff did not have access to the correct clinical waste products and had not followed infection control principles when discarding clinical waste. Staff had not completed handwashing training for 12 months.
- Staff did not routinely monitor patient's physical health after intramuscular antipsychotic medication was administered as rapid tranquilisation.
- Some improvement had been made regarding mandatory training. However, only 62% of staff had completed mandatory training and 70% completed refresher training.

However:

- Managers had completed comprehensive ligature risk assessments for all wards and these were up to date.

Summary of this inspection

- Staff were not using restrictive practices to manage risks for patients.
- Managers ensured that covert medication plans were in place for patients where required.
- The hospital was now compliant with guidance on same sex accommodation.
- Clinic rooms were fully equipped and stocked with emergency drugs. Nurses checked and recorded the equipment and medication regularly to ensure equipment was not faulty and if medication was in date.
- Environmental audits of the kitchen, lounges and bedrooms were detailed and demonstrated that staff had reviewed the environment within the service.
- The provider had systems in place to ensure that agency staff were appropriately trained prior to working with patients.
- All staff had disclosure and barring service checks in place.

Are services effective?

This inspection was carried out to follow up and review action taken by the provider against warning notices issued following an inspection in November 2015.

At this inspection of May 2016 we found:

- The majority of care plans were fully completed and reviewed regularly.
- Staff ensured the patient's physical health was monitored regularly. This included blood tests and electrocardiograms.
- Staff monitored and recorded patients fluid intake when required to ensure that were receiving the recommended daily allowance. The multidisciplinary team and dietitian reviewed fluid charts regularly.
- Staff assessed patients' capacity to consent on a decision-specific basis.

Are services caring?

Not inspected

Are services responsive?

This inspection was carried out to follow up and review action taken by the provider against warning notices issued following an inspection in November 2015.

At this inspection of May 2016 we found:

- Oakley male ward had been fully refurbished and promoted the comfort and dignity of patients on the ward.

Summary of this inspection

- Complaints were investigated and outcomes and lesson learnt were shared with the complainant and discussed in monthly meetings.
- Activity rooms were available across the service that were equipped with games and activities.

However we found the following issue that the service provider needs to improve:

- Observation windows in bedrooms had been covered in wallpaper. Whilst this promoted patients' privacy and dignity it did not allow patients to be observed discreetly.

Are services well-led?

This inspection was carried out to follow up and review action taken by the provider against warning notices issued following an inspection in November 2015.

At this inspection of May 2016 we found the following issues the service provider needs to improve:

- Senior managers attended three different monthly meetings to discuss the service wide improvements and any arising issues. However, the content of the meetings varied and it was not clear how these meetings shared information or how the information was disseminated across the service.
- Although the managers had completed audits it was not clear what action had been taken to address actions identified within the audits.
- Managers did not ensure that they monitored the reporting of incidents. Although they had identified what action needed to be taken to address some issues we found no evidence that this had been embedded in practice or that they had maintained up to date records.
- Senior managers did not have robust monitoring systems in place for monitoring the outcomes of safeguarding incidents and to ensure that external agencies were notified a timely way.

However:

- The provider had put an action plan in place to improve compliance with mandatory training.

Detailed findings from this inspection

Mental Health Act responsibilities

Not inspected.

Mental Capacity Act and Deprivation of Liberty Safeguards

Not inspected.

Notes

Long stay/rehabilitation mental health wards for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are long stay/rehabilitation mental health wards for adults safe?

Safe and clean environment

- The layout of the service meant all wards had blind spots. Staff could not observe areas of the wards at all times to keep patients safe. Although the provider had installed mirrors to mitigate this risk, some mirrors were in areas that did not improve staffs lines of sight.
- Managers completed comprehensive ligature risk assessments for all wards and these were up to date. However, we found that the ligature audit for Oakley male ward was titled with the previous wards name.
- The hospital was now compliant with guidance on same sex accommodation. Managers had reconfigured the wards. They had moved male patients on Oakley Ward to a newly refurbished ward in order to meet the guidance.
- Staff or patients had used furniture to prop doors open on all wards across the service. For example, the kitchen door on Burberry was propped open with a bin, Room 32 and 33 on Mulberry ward with a washing basket and chair. The propping open of doors was in breach of both health and safety, and fire regulations.
- The provider had replaced a keypad door locking system with a fob system. Whilst this allowed staff to move across the service more easily not all staff had fobs. This meant that some staff had to remember the different door numbers to access clinical and non-clinical areas. We observed three staff that had difficulty in using the fobs and the keypad system during the inspection.
- Clinic rooms were fully equipped and stocked with emergency drugs. Nurses checked the equipment and medication regularly to ensure that equipment was not faulty and medication was in date. Each ward had a different system of recording this information. The provider acknowledged that these recording systems varied on each ward and did not allow staff to fully record their findings or actions taken. The provider told us that they are reviewing this to ensure there is a consistent approach across the service, that staff record any equipment faults or out of date items, and that any issues found are addressed.
- We found the emergency bag on Mulberry ward had a pulse oximeter that had been without batteries from 09 September 2015 to 01 May 2016.
- Staff knew where the emergency equipment was stored. Mulberry and Burberry have their own emergency bags. Oakley and Radley shared an emergency bag. We observed that staff were able to move equipment between wards in under three minutes. Although, the member of staff that we observed found it difficult to move the bag due its size and weight.
- The provider had installed a key fob system to replace the keypad locking system. This reduced the risk of staff forgetting the different number combinations and allowed staff to move throughout the service quickly if required. Although we noted that some staff had difficulty opening the doors with the key fob on the first attempt.
- Environmental audits of the kitchen, lounges and bedrooms had been completed. These were detailed and demonstrated that staff reviewed the environment within the service, its cleanliness and repairs were completed when required.
- All ward areas were clean and had good furnishings that staff maintained.
- Staff were not provided with the correct infection control equipment to assist them in carrying out the duties in line with guidance. For example, the minutes of clinical governance meeting highlighted that managers reported they did not have the correct clinical waste

products. For example, in February 2016 staff reported that they did not have tie straps to ensure that clinical waste bags were closed correctly in line with guidance. The minutes noted that these had been in ordered. In March and April 2016 the minutes recorded that they were still waiting for the delivery of tie straps. These minutes also highlighted that staff had not completed handwashing training for 12 months.

- We observed that outside storage areas for clinical waste bins was dirty. One of the bins had not been locked and contained sharps bins that had not been correctly signed when opened and closed, in line with infection control principles. We reported this at the time of the inspection and the manager stated they would follow this up.
- Staff ensured that equipment was well maintained and clean. Cleaning records were up to date and demonstrated that the environment was cleaned regularly. However, during the inspection staff told us that domestic staff only worked Monday to Fridays which meant that nursing staff would carry out cleaning duties at the weekend when required. A staff member reported that this took nurses away from their nursing duties.

Safe staffing

- We carried out a check of staffing numbers across the service. All wards had the required numbers and grade of nurses to meet the needs of the patients during the inspection.
- The human resources team provided a list of staffing establishments from 18 May 2016.
- The human resource co-coordinator had a system in place to monitor and block book agency staff where appropriate. They ensured that if a member of agency staff did not have the required training they would not be booked to work at the service until they had completed the necessary training.
- We reviewed 11 staff records on the electronic human resource system. We found four files which did not have the two required references on file. One member staff had not been entered on the system.
- All staff had disclosure and barring service checks in place. If the disclosure and barring service checks highlighted convictions, managers had completed a risk assessment. For example, one file showed that a member of staff had declared a previous conviction in relation to the handling of money. Managers had assessed this person and deemed that they could be supported to manage a patient's finance through four weekly supervision.
- Senior managers had set a target of 90% for mandatory training completion for all staff to achieve. Between May 2015 and May 2016, 62% of staff had completed mandatory training and 70% had completed refresher training.
- The service had employed a HR co-coordinator and training manager who oversaw and co-ordinated all staff training. This included, managing a database of attendance at both mandatory and specialist training. If staff failed to attend training, managers ensured that clear timeframes were set for them to complete the training and staff were informed that disciplinary action may be taken. This process was introduced in June 2016 and the training compliance rate has risen to 78%.

Assessing and managing risk to patients and staff

- We reviewed 15 patient risk assessments. Staff had not fully completed, or updated eight risk assessments after incidents. One patient did not have a risk assessment in place, we asked staff to locate this during the inspection but they could not. The remaining seven risk assessments were fully completed and updated after incidents. Staff had set review dates on all risk assessments and old risk assessments had been archived. Staff told us that when the updated or reviewed risk assessments they recorded this in the case notes. However, when asked they could not show inspectors evidence of this.
- We reviewed care plans that identified the use of restrictive practices that staff had implemented to manage risks for three patients during the last inspection. We found that staff had reviewed all three care plans and stopped using restrictive practices.
- We reviewed 24 safeguarding incidents. Eleven of the incidents had been reported to the external safeguarding team three or more days after the event took place. The service had developed a safeguarding database to record all safeguarding incidents. However, this had not been updated since January 2016. A senior manager was not able to describe to us the process of logging, monitoring or themes in relation to safeguarding at the service. They told us that safeguarding was discussed as a regular agenda item at the clinical governance meeting. We reviewed minutes

of this meeting from January to May 2016 and safeguarding was discussed, though the discussions were variable in content. For example, we saw some minutes highlighted that full discussion had taken place regarding the incident, actions taken and outcomes. However, at the meeting held in February, safeguarding incidents had not been discussed; the minutes of the meeting did not document the reason for this.

- The medication trolley on Oakley ward was secured to the wall in the dining room. Covert medication care plans were in place for patients that required them. All were in date and fully completed by the multidisciplinary team. Managers told us that a community pharmacist carried out audits of medication management. Staff would ensure that the identified issues were actioned. We saw evidence of this. However, we found three missing signatures on medication charts. In patients case notes it was recorded that patients were administered ibuprofen medication four times but the medication chart showed that staff had administered co-codamol.
- Staff did not routinely monitor patient's physical health after intramuscular antipsychotic medication had been administered as rapid tranquilisation. The following is required according to the British National Formulary 2015 after intramuscular injection is given; blood pressure, pulse and respiratory rate should be monitored for at least 4 hours.

Reporting incidents and learning from when things go wrong

- There had been 24 safeguarding incidents, of which only six were notified to the CQC.
- Staff and managers did not follow the internal procedure for reporting incidents. Out of 51 incidents forms reviewed during the inspection, four had not been competed fully, seven did not have an incident type identified, and one form had an incorrect category selected.
- We found 10 incidents recorded in patients' case records where staff had not completed incident forms within the electronic system. Staff on two occasions had completed incident forms but not recorded the incident in patients' case records.
- Minutes of a hospital managers meeting showed that senior staff discussed incidents and highlighted that managers needed to ensure that they recorded the outcomes of incidents within the electronic system. However, we found 33 out of 51 incident forms where managers had not reviewed or recorded actions taken or the outcomes.

Are long stay/rehabilitation mental health wards for adults effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- We reviewed 15 care plans and found the provider had made progress in some areas. The majority of care plans were fully completed and reviewed regularly and there was evidence that patients had been involved in writing the plans. However, two care plans had not identified interventions that supported patient needs; two were not fully completed or linked to risk assessments. When staff reviewed care plans they did not record the review date in case records. There was no evidence that patients had copies of their care plans.
- Doctors ensured that blood tests were recorded in case notes. Staff also recorded if a patient had declined to have bloods taken. Electrocardiograms were regularly completed. We found evidence that doctors has changed two patients' medication regimes due to abnormal blood results. However, we also found that one patient's prolactin levels had been high since 2014 and there was no evidence that this had been addressed.
- Care records show that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems.

Best practice in treatment and care

- Staff referred patients to specialist services when required and this was documented in case notes.
- The average daily fluid intake for patients had increased to within the Association of UK Dietitians (BDA) recommendations for the majority of patients. Although, three patients were below at 950mls, 980mls, and 790mls. These patients had been reviewed regularly by the multidisciplinary team and dietitian with no concerns noted. We found evidence in case notes that when patients were not eating or drinking staff offered

alternative meal/drink options and they continued to encourage patients to eat/drink. Staff discussed patient's fluid intake weekly in multidisciplinary team meetings and this was evidenced in case notes.

- The ward manager on Oakley ward had trained staff to ensure that patients' fluid charts were completed accurately and regularly throughout the day. The manager audited this paperwork weekly to check that the correct process was being adhered to by staff and that patients were drinking the adequate amounts of fluid. If staff or the manager noted any concerns they contact the dietitian and/or discussed with the multidisciplinary team without delay.
- The staff information board on Mulberry ward highlighted that six patients needed their fluid intake monitored. However, only four patients had fluid charts. We reviewed the case notes and found that this was correct. Staff had not updated the information board. This was fed back for the manager to action during the inspection.
- We looked at a case record audit and checked the outcome for 13 case records. The audit highlighted if a document was present or missing in the patients cases notes. It was not clear what action was taken to address any issues where this was identified. However, staff on Oakley ward had completed their own audit of out of date care plans and risk assessments. This audit clearly identified records which were out of date. Staff were then emailed to instruct them to update the care records

Skilled staff to deliver care

- Managers dealt with poor staff performance. We saw that managers had carried out disciplinary investigations when concerns had been raised about staff. Managers had issued written warnings and extended probation periods if required in order to support staff to improve their practise. However, we saw one member of staff had multiple issues raised about their conduct but there was no evidence on file as to what action was taken. The alleged incidents were serious and classed as gross misconduct as outlined in the provider's policy.

Multi-disciplinary and inter-agency team work

- All wards used a new ward round template to discuss patients care. The template was fully completed and provided details about patients' physical and mental wellbeing. However, the actions were standardised and it was not clear if the actions had been carried out as they were repeated in every ward round. The template was not linked into case notes as it was a separate document, so it was difficult when reading case notes to know when the multidisciplinary team had reviewed patients care.

Good practice in applying the MCA

Staff assessed patients' capacity to consent to medical treatment and documented this in case notes. We saw that this was carried on a decision-specific basis with regards to significant decisions.

Are long stay/rehabilitation mental health wards for adults caring?

Not inspected.

Are long stay/rehabilitation mental health wards for adults responsive to people's needs?

(for example, to feedback?)

The facilities promote recovery, comfort, dignity and confidentiality

- Activity rooms were available across the service. They were equipped with a variety of games and activities that were used by staff and patients.
- Oakley male ward, which was previously part of Mulberry ward, had been fully refurbished. We saw that it promoted patients comfort and dignity as a kitchen diner had been built for patients to make their own drinks and food and sit at a dining table to eat.
- On Radley ward bedroom observation windows had been covered in wallpaper. This supported patients' privacy and dignity but did not allow patients to be observed by staff unless they entered the room. One patient did not want to have their window covered. Staff had written a care plan to support their decision.

Listening to and learning from concerns and complaints

- We reviewed the last six complaints that staff had recorded on the complaints log. The log listed the type

of complaint, the name of complainant, outcomes, lessons learnt, and action plans. The log was fully completed. However, we found a patient alleged staff had administered them the wrong medication. An action plan identified that the patient was to be given medication information and medication training would be offered to all patients. There were no lessons learnt or actions for staff to ensure that similar complaints were not raised.

Are long stay/rehabilitation mental health wards for adults well-led?

Good governance

- The provider had an action plan in place to ensure that the staff received mandatory training to meet the target of 90% compliance.
- We reviewed the minutes of hospital managers meetings from January 2016 to April 2016. Managers had identified actions that needed to be completed with named individuals responsible and dates set for completion in the January and March meetings. However, this was not the case for February and April meetings. Managers did not address matter arising from the previous meetings. In April's meeting there were 23 outstanding actions which had not been completed, the reasons for non-completion had not been discussed or recorded in the minutes.
- The provider had made changes to the clinical governance meetings to improve the system and to monitor the quality of the service. Managers had been identified to undertake actions that needed to be completed. These were monitored until they had been completed.
- We reviewed the board meeting minutes held in May 2016. The meeting covered a variety of topics which included safeguarding, incidents, audits and staffing. The document highlighted what actions had been implemented to improve the quality of the service. If issues had been identified by the board a named individual was highlighted with actions to complete and feedback.
- Whilst the service had three separate meetings to review their systems and processes, it was not clear how these meetings shared information or how the identified actions or learning from these was disseminated across the service.
- The provider had replaced a keypad door locking system with a fob system. Whilst this allowed staff to move across the service more easily, not all staff had fobs. This meant that some staff had to remember the different door numbers to access clinical and non-clinical areas. Since the managers had installed the fob system across the service they had not implemented a system to check if all permanent staff had access to the fobs when working. Nor had they developed a system to monitor agency or bank staff access to the fob when working and handing the fob in at the end of the shift. This meant that on occasions there were not enough fobs in the service and staff had to rely on the key pad door lock.
- Although the managers had completed audits it was not clear what action had been taken to address issues identified within the audits. The audits were not robust. For example, the case file audit identified if documents were missing rather than the detail within or quality of the document. The patients' money audit did not include balance checks.
- Senior staff discussed safeguarding in detail, which included actions taken and some lessons learnt. However, not all actions that the provider was required were taken. For example there were delays in reporting safeguarding to external agencies including the CQC. The safeguarding database had not been kept up to date.
- Managers had ensured that the complaint log was kept up to date and discussed outcomes and lessons learnt in monthly meetings.
- The reporting and monitoring of incidents remained inaccurate. Incident forms had not been completed for all incidents or recorded in case records. Whilst senior managers were aware of these issues, and were discussing them in meetings, we did not find evidence that there had been any improvement.

Leadership, morale and staff engagement

- Staff were offered the opportunity to complete a staff survey to give feedback on the service. In March 2016, 13 staff had completed the survey. However, there was no analysis of the feedback or resulting action plan. Although the service had a plan to undertake random monthly surveys with a target to survey all staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that incident reports are fully completed and that incidents are fully investigated and learnt from.
- The provider must ensure that all patient risk assessments are fully completed and reviewed regularly and following incidents.
- The provider must ensure that they have a robust system to review safeguarding incidents and ensure that the safeguarding incidents are reported to external agencies without delay.
- The provider must ensure they have an effective system in place to monitor and improve the quality of the service, including robust audits.
- The provider must ensure that they have adequate stock clinical waste products.
- The provider must ensure that staff monitor patients physical health after administering intramuscular mediation
- The provider must ensure that doors are not propped open with furniture
- The provider must ensure that they meet their compliance rate of 90% for mandatory training.

Action the provider SHOULD take to improve

- The provider should ensure that information about service wide improvements is shared across the service.
- The provider should ensure that all medical equipment is in full working order.
- The provider should ensure that mirrors are correctly positioned to mitigate the risks in all blind spots across 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have a robust system in place to ensure that care and treatment was provided in a safe way for service users. • We found the provider did not ensure that all risk assessments were fully completed. • The provider did not ensure that all incident reports were fully completed for all incidents that had occurred. • The provider did not ensure they had adequate stocks of clinical waste product. • The provider did not ensure that patients' physical health was monitored after administering intramuscular medication. • Premises were not safe to use due to bedroom doors being propped open in breach of health and safety and fire regulations • The provider did not ensure that all staff had received mandatory training and had not achieved their compliance rate of 90%. Regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

- We found that the provider did not have a robust system to review safeguarding incidents or ensure that incidents were reported to external agencies without delay.

Regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Providers must operate effective systems and processes to make sure they assess and monitor their service. • The provider did not ensure they have an effective system in place to monitor and improve the quality of the service including robust audits. • The provider did not ensure that all incident forms were fully completed. They did not have effective systems and processes to record and monitor or sharing lessons learnt from or incidents which included safeguarding. Regulation 17