St Neots Neurological Centre

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

Overall summary

St Neots Neurological Centre provides long stay and rehabilitation wards for adults with severe and enduring mental health needs.

We did not rate this service at this focused inspection. We carried out this inspection in response to a high number of whistleblowing concerns and concerns about how some patients had been supported.

We found the following issues that the provider needs to improve:

- Staff had not always followed care plans and had not consistently kept patients safe from avoidable harm. Two patients had sustained injuries in incidents which could and should have been avoided.
- Staff had not completed all patient records to a good standard. There were gaps in some falls assessments and recommendations were not always carried out or recorded.
- Cleaning schedules for all wards were poorly recorded. Audits had not identified and addressed this issue.
- There were insufficient computers on the wards for all staff to have easy access to patient records. Agency staff did not have access to the hospital's computer system and had to rely on permanent staff, printouts and handovers which meant they could not be sure they had up-to-date patient information.
- There was a lack of meaningful activities or personalised timetables for patients.

However, we found the following areas of good practice:

- The ward environments were safe and clean. Managers had put systems in place to ensure that staff had access to personal protective equipment and that staff used it correctly. Managers adhered to company-wide processes to ensure they never ran out.
- The wards had enough nurses and doctors and followed good practice with respect to safeguarding.
- Staff we spoke with felt respected, supported and valued. They felt able to raise concerns without fear of retribution. They were knowledgeable, confident and skilled when treating patients.
- The provider gave thorough handovers and maintained detailed records for staff who were not present.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They involved patients and families and carers in care decisions.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

Summary of findings

- Managers monitored the performance of the team. They were aware of the impact of Covid-19 in reducing supervisions, face to face training and team meetings but had plans in place to address this.

Summary of findings

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Background to St Neots Neurological Centre

St Neots Hospital provides long stay and rehabilitation wards for adults with severe and enduring mental health needs. It specialises in caring for patients with complex and co-morbid mental health and physical health conditions, including progressive neurological conditions and patients in the latter stages of their diagnosis.

St Neots Neurological Centre has been registered with the Care Quality Commission under its current owner Elysium Healthcare since December 2016 for:

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

The service was last inspected on 15 and 16 August 2019 and was rated good across all domains. The report for this inspection was published in October 2019.

The service has 4 wards:

- Cherry ward – 8 beds for women
- Maple ward – 11 beds for women
- Rowan ward – 7 beds for men
- Willow ward – 12 beds for men

During this focused inspection, we looked at Cherry, Maple and Willow wards.

Our inspection team

The team that inspected the service comprised a head of hospital inspections, four CQC inspectors and a nurse with experience of working with patients who have neurological conditions..

Why we carried out this inspection

We carried out this inspection in response to concerns about how four specific incidents had occurred and about how staff had supported and cared for patients. In addition, we received a number of whistleblowing concerns about care practices, including these incidents and a lack of managerial support.

How we carried out this inspection

At this focused inspection, we considered the following questions:

- Is it safe?
- Is it caring?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, attended five safeguarding meetings, spoke with 11 care co-ordinators and commissioners for information and sought feedback from carers.

During the inspection visit, the inspection team:

- visited three wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with two patients who were using the service;
- spoke with five carers who were using the service;
- spoke with the registering manager and managers or acting managers for two of the wards we visited;
- spoke with 16 other staff members; including doctors, nurses, occupational therapist and social worker;
- received 11 feedback reports from staff members;

Summary of this inspection

- spoke with an independent advocate;
- Looked at eight care and treatment records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with two patients who were being cared for at the service, who were positive about living at the service. They said staff were friendly and looked after them well and took them out on outings. They said they could personalise their rooms and make hot and cold drinks when they wanted.

We spoke with six carers of patients at the service. Carers were confident about the treatment their relative had received from staff, including the doctors. They said staff were friendly and respectful and helped their relative keep in touch with them through phone calls and teleconferencing. However, three carers said that communication could have been better at times and that on occasions they had not been contacted or that there had been an issue with the telephone system when they rang. One said that communication had improved over the last two years and two felt that the Covid-19 outbreak had led to more agency staff working at the service who had less experience and did not know the patients well.

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?

We did not rate this service at this focused inspection. We found the following issues that the provider needs to improve:

- Staff had not always followed care plans and had not consistently kept patients safe from avoidable harm. Two patients had sustained injuries in incidents which could and should have been avoided.
- There were insufficient computers on the wards for all staff to access patient records in a timely manner. Agency staff did not have access to the hospital's computer system and had to rely on permanent staff, printouts and handovers which meant they were not always fully aware of all the needs of the patients.
- Bank staff were not up to date with physical interventions training and with 15 of the 23 mandatory e-learning training courses.
- Cleaning schedules for all wards were poorly recorded, which meant that senior staff could not be assured that cleaning had been performed and patients protected from risk of infection.
- Staff had not completed all patient records to a good standard. There were gaps in some falls assessments and recommendations were not always carried out or recorded.
- Two airflow mattresses had not been calibrated to the correct pressure and one had been turned off. This increased the risk of skin abrasions and pressure sores.

However, we found the following areas of good practice:

- All wards were safe, clean, well equipped, well-furnished and maintained and fit for purpose.
- Managers had put systems in place to ensure that staff had access to personal protective equipment and that it was used correctly.
- Managers reported and investigated incidents thoroughly, maintained communication with the safeguarding team, care co-ordinators and families and made changes as a result.
- Staff were knowledgeable, confident and skilled when treating patients.
- The provider gave thorough handovers and maintained detailed records for staff who were not present could access up-to-date information about patients.

Summary of this inspection

Are services caring?

We did not rate this service at this focused inspection. We found the following areas of good practice:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity and understood their individual needs.
- Staff ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However, we found the following issues that the provider needed to improve:

- There was a lack of meaningful activities or personalised timetables for patients.

Are services well-led?

We did not rate this service at this focused inspection. We found the following issues that the provider needs to improve:

- Managers had not ensured that cleaning schedules had been recorded correctly and infection prevention and control audits had not identified and addressed this issue. This meant senior staff could not be assured that cleaning had been performed and patients protected from risk of infection.
- Although staff used handovers and printouts effectively, there were not enough computers for all staff to have easy access to patient records.
- Agency staff did not have access to the hospitals computer system, including to patient records.
- Not all staff felt supported. We received anonymous reports from several staff stating that managers were unsupportive, did not listen to them and that they did not feel safe to raise concerns.

However, we found the following areas of good practice:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Managers provided enough personal protective equipment to protect staff and patients from the beginning of the outbreak. Managers adhered to company-wide processes to ensure they never ran out.
- Staff we spoke with felt respected, supported and valued. They felt able to raise concerns without fear of retribution.

Summary of this inspection

- Governance processes operated effectively at team level. Managers monitored the performance of the team. They were aware of the impact of Covid-19 in reducing supervisions, face to face training and team meetings but had plans in place to address this.

Long stay or rehabilitation mental health wards for working age adults

Safe	
Caring	
Well-led	

Are long stay or rehabilitation mental health wards for working-age adults safe?

Safe and clean environment

Ward areas were clean, had good furnishings and were well-maintained. We observed staff cleaning regularly throughout the day and staff we spoke with said housekeeping staff were thorough and aware that cleaning strategies had been enhanced due to Covid-19. However, although the wards were clean, cleaning records were not up to date and did not demonstrate that the ward areas were cleaned regularly. There were gaps in the recording schedules and there was no evidence that staff had conducted any audits to identify and rectify this. We were assured on all the wards we visited that this was a recording issue and that the wards were cleaned to a good standard.

Staff followed infection control policy, including handwashing. There were clear protocols in place in relation to containing the spread of Covid-19 relating to the wearing of personal protective equipment, including face masks, gloves, aprons and goggles where necessary. Staff used fresh masks and gloves each time they entered and left the ward environment.

Some staff had contacted the CQC to say that the correct personal protective equipment had not been available at the beginning of the Covid-19 outbreak and that staff were not following hand hygiene procedures. However, staff we spoke with told us personal protective equipment had been available from the beginning of the outbreak and that the service had never run out. Staff submitted a stock balance chart which was sent to head office twice weekly. Stock was ordered from head office or through local providers. Each ward identified what they needed which was distributed daily. Additionally, a room was designated on Maple ward where a stock supply was left for staff to access out of hours.

Two of the airflow mattresses were not set correctly and one of them had been switched off. This increased the risk of skin abrasions and pressure sores. We raised this with the provider who addressed this issue and checked the mattress settings on the other wards.

The ward complied with guidance and there was no mixed sex accommodation.

Safe staffing

The service deployed enough nursing and medical staff. Permanent and bank staff knew the patients and received basic training to support them. Where possible, managers tried to use agency staff who were experienced and who the patients, but since the outbreak of Covid-19, the numbers of agency staff had increased, and this was not always possible.

Managers had calculated the number and grade of nurses and healthcare assistants required. The ward manager, in consultation with the registering manager, could adjust staffing levels according to the needs of the patients.

We looked at rotas for a six week period. Between 1 May and 14 June 2020, 720 shifts were filled by agency staff, 125 shifts were filled by bank staff and 21 shifts were left unfilled. This meant there were 21 occasions without appropriate staff in place.

A registered nurse was present in communal areas of the ward at all times.

Staff we spoke with told us there were generally enough staff to look after patients well but that when there were incidents or when staff took breaks this put additional pressure on the staff teams.

Managers tried to limit their use of bank and agency staff and requested staff familiar with the service. The service specified that staff who worked at the hospital could not work anywhere else. However, the Covid-19 outbreak had meant that agency usage had increased, due to permanent staff being off sick or shielding. There were some occasions where less experienced agency staff supervised patients, including those on individual observations.

Long stay or rehabilitation mental health wards for working age adults

Staff shared key information to keep patients safe when handing over their care to others. Notes of handover meetings were thorough and staff we spoke with told us that handovers provided up to date evaluations of patient risk. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, agency staff did not have access to electronic records.

Permanent staff had completed and kept up to date with most of their mandatory training. Data from the provider stated that as of 12 June 2020, 87% of staff had completed mandatory training. However, only 47% of permanent staff were up to date with physical interventions training, 64% with security training and 72% with immediate life support. These courses were face to face training and had been cancelled or reduced since the beginning of the outbreak. Courses had been scheduled to re-establish face to face training but at half the capacity as before the Covid-19 outbreak. By 27 July, 48% of staff had completed physical interventions training and 69% had completed security training. The manager had plans to ensure more staff were up to date with their training and had scheduled a number of additional courses to address this backlog.

Bank staff had not completed and kept up to date with their mandatory training. Overall, 64% of bank staff were up to date with their mandatory training with only 33% up to date with physical restrictions training, 41% with security training and 50% with immediate life support. There were 12 e-learning courses where less than 75% were up to date, for example, safe administration of medication at 42%, infection control levels one and two at 64% and 57% respectively, Mental Capacity Act and DoLS training at 52% and food hygiene at 68%. By 27 July, 74% of staff were up to date with infection control level one and 77% with level two.

We observed staff interacting with and treating patients. They were confident and knowledgeable, for example about care plans and safeguarding plans and in giving thickened food and drinks to patients.

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient and reviewed this regularly, including after incidents. We looked at eight patient records. Each contained up-to-date risk assessments and care plans which staff reviewed in the light of any new information or after an incident. Most records were detailed and specific.

However, not all patient records were completed well. For example, one patient's risk rating was inaccurately recorded. Another patient's risk assessment described triggers for particular behaviours but did not identify any plans to manage this behaviour.

We were concerned about how the service assessed and managed patients with falls, following concerns raised by staff in relation to a particular patient who had a history of falling regularly, both prior to and since admission to the hospital. We looked at eight patient records. Three multi-factorial falls risk assessments were incomplete and poorly recorded; one of these assessments recommended a referral to the GP and physiotherapist but there was no evidence that this was completed. However, we reviewed how the service managed this patient and found staff reviewed their falls daily and held regular multi-disciplinary reviews to discuss how best to manage this. They looked at the effectiveness of 1:1 observations, conducted environmental risk assessments to identify particular risks and made modifications to the environment, referred to specialist services and ordered protective equipment to reduce the impact of any falls. We also looked at how the service had addressed issued for another patient who had fallen. Staff discussed this at a falls meeting, sensor mats were ordered, and 1:1 observations were requested and agreed with commissioners. This was reviewed regularly, and further plans put in place or agreed with commissioners, for example for continued 1:1 observations.

Staff knew about risks to each patient but had not always acted consistently to prevent or reduce risks. We were concerned that a patient sustained injuries because staff did not follow their care plan. Another patient required an emergency admission to hospital because concerns had not been raised in a timely fashion. A further patient had been prescribed a covert medication (now discontinued, as the patient had regained capacity) which stated that it should not be given with dairy products; whilst this was correctly recorded and a Mental Capacity assessment and best interests decision was in place, staff told us that this was usually given with yoghurt or tea.

Long stay or rehabilitation mental health wards for working age adults

There were not enough computers on each ward for all staff to access patient records consistently. There were two computers on each ward and when there was a large number of 1:1 observations, there could be as many as eight staff on some of the wards. We received three reports from staff prior to our visit, stating that keeping up to date with risk assessments and care plans was difficult due to the number of computers on the ward. Staff also raised this with us during our visit. Managers were aware of this issue but there were no plans to address this. Staff we spoke to on the ward said that risk assessments were printed off and that handovers were full and thorough and gave them the most up-to-date information they needed to support patients.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training with 93% of permanent staff and 91% of bank staff compliant for safeguarding adults and children training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Patient notes were comprehensive, and all permanent staff could access them via computers on the wards. However, there were only two computers on each ward, which posed difficulties when wards had large staff numbers. At these times it would not always be possible for staff to access patient records consistently.

Not all staff had easy access to patient notes. Agency staff did not have access to patient records as they did not have computer login. These staff relied on printed versions and handovers.

Records were stored securely.

Track record on safety

There were two incidents in May 2020 where patients were injured during 1:1 observations, one where staff did not secure a patient in their wheelchair and another where they grazed their leg and arm between bedrails and the mattress. There was also an incident where a patient sustained a bruise to the eye; the cause of this is not known but the sensor mat used during the night was not plugged in correctly and was not functioning. In a further incident, a patient required an urgent admission to hospital to attend to a blocked catheter because the hospital had not raised this in a timely manner.

The service has had seven deaths since 1 April 2020. Four of these have been related to Covid-19.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where possible. We participated in five safeguarding strategy meetings, which included carers and care co-ordinators. The provider was transparent in reporting on these incidents and in investigations involving hospital staff and hospital processes, including potential failings and learning points.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. We saw additional memos and communications to staff in relation to incidents, additional training being provided and changes to care plans. Managers also took action to prevent or reduce the possibility of patients' sensor mats not working correctly.

Are long stay or rehabilitation mental health wards for working-age adults caring?

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for patients. We observed staff engaging with patients in a kind and supportive way, taking their time to make themselves understood and respond appropriately. Prior to this inspection we received three reports questioning whether some staff cared about patients, but we found no evidence of this when speaking to staff and observing care.

Long stay or rehabilitation mental health wards for working age adults

Staff gave patients help, emotional support and advice when they needed it. We observed staff giving help and support to patients throughout the day. However, there was a lack of meaningful activities or personalised timetables for patients. We raised this with the provider who told us that many patients who had contracted Covid-19 had not returned to their former level of functioning which has had a negative impact on patients' capacity and motivation to participate in the same level of activities as they did before. The provider acknowledged there was a lack of personalised activity plans and said this was being reviewed.

Staff understood and respected the individual needs of each patient. Staff we spoke with knew and understood their patients well and what they needed to do to support them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff we spoke with told us they felt safe to raise issues with managers if they felt patients were not being treated in a caring way. However, we received three anonymous webforms from staff saying they did not feel safe to raise issues and three saying that some, unnamed, staff did not treat patients in a caring manner. We raised this with the provider but could not provide further information.

Involvement in care

Staff made sure patients could access advocacy services. The service commissioned an advocate for a day a week who had regular contact with patients. Although the advocate had not been available to speak to patients face to face since the outbreak of Covid-19, they had continued to contact patients via telephone and teleconferencing.

Staff supported, informed and involved families or carers. Staff arranged for carers to speak to their relatives using a tablet, laptop or telephone.

Staff helped families to give feedback on the service.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The hospital appointed a new manager at the beginning of June 2020 who was working to address the issues raised by whistle-blowers and by the incidents referred to in this report.

Culture

We received 16 feedback reports prior to visiting the hospital, raising concerns about managers; it was not clear how many staff this represented. However, staff we spoke with remotely and face to face during the inspection, told us differently. Staff we spoke with told us they felt respected, supported and valued. They said they could raise any concerns without fear and that managers were supportive, helpful and prepared to come to the wards and help out when needed. All said that managers had been supportive at a very difficult time, after many staff and patients had contracted Covid-19 and four patients who had died and had tested positive for Covid-19. Due to the stark, contradictory feedback, we have told the provider to improve communication with staff and ensure there is an effective system for all staff to feel able to raise concerns.

Some staff did not feel well supported. We received information from seven webforms prior to the inspection that were critical of management, stating that managers were unsupportive, did not listen to staff and failed to protect patients. After this we wrote to all staff giving them an opportunity to raise issues with us if they wished to do so. We received a further eleven webforms, nine of which were critical of managers. They also stated that managers were unsupportive and did not listen to them, that it was not safe to raise concerns and there should be more staff given the amount of paperwork they had to complete. The positive feedback we heard on site may have been due to

staff being fearful of reprisal or a genuine reflection of their views. It was not possible to make a clear judgement. We will continue to monitor this area of concern via our regular engagement meetings.

Staff morale had been seriously affected by the outbreak of Covid-19. Many staff were off shielding or in isolation due to them having symptoms or having contact with people who had symptoms. In addition, many staff who tested positive to Covid-19 had not displayed symptoms and did not go on to display symptoms, but did need to isolate themselves for a period. As a result of staff being absent, the hospital had to increase their use of bank and agency staff and this had an impact on the hospital's capacity to deliver supervision effectively. Some of the staff who have been absent were key members of the team, including the associate specialist doctor and the lead nurse. These staff continued to work and contacted the wards daily but were not on site.

Managers changed a variety of processes and systems as a result of the Covid-19 outbreak. Team meetings and face to face training ceased. The morning meeting, attended by representatives from all the wards, was replaced by one person picking up issues from each ward and collating this centrally. This process was not interactive and led to nursing staff feeling less involved and knowledgeable about issues within the hospital.

The hospital provided enough personal protective equipment to protect staff and patients at the beginning of the outbreak. Although we received two reports that the correct equipment was not easily available, all staff we have spoken with have said equipment was available and staff used it correctly. Staff also stated that managers were supportive and provided clear guidance.

Governance

Although the environment appeared clean on all the wards we visited, senior staff could not be assured that cleaning had been performed and patients protected from risk of infection. Cleaning schedules for all wards were poorly completed with multiple gaps. The monthly audit reports for February, March, April and May identified that daily infection control audits were completed daily due to Covid-19. However, there was no evidence that staff or managers had conducted audits in this area which would have identified this issue. The service had an infection prevention and control action plan from June 2020. However, this also contained some significant gaps and lacked detail about its frequency, content, specific information about who had conducted it and who would undertake the actions identified. It was not clear how this action plan fed into clinical governance processes.

Managers monitored the performance of the team. They were aware of the impact of Covid-19 in reducing supervisions, face to face training and team meetings but had plans in place to address this.

Staff undertook or participated in other clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. We saw evidence of monthly audits for grab bags, NEWS 2, mattresses and medication as well as less frequent audits, such as handovers, slings and enhanced observations.

Staff had implemented recommendations from recent incidents and safeguarding alerts at the service level.

Management of risk, issues and performance

Managers had introduced a system for ensuring sufficient personal protective equipment was available at all times. The hospital had not run out at any stage.

Managers had experienced difficulties since the outbreak of Covid-19 in monitoring the performance of the teams. Team meetings, including reflective learning sessions, and face to face training no longer took place. This had impacted on the service's ability to communicate learning to the staff group.

Managers were aware that supervision and training figures were low and the reasons for this and had a plan to ensure staff were trained to the appropriate level. Due to staff absences, the supervision of staff also reduced. Between 1 December 2019 and 29 February 2020, 90% of staff received supervision in line with the provider's policy. Between 1 March and 31 May 2020, this had reduced to 60% and in April was only 51%. However, by 27 July, this had increased to 80%.

Managers ensured permanent staff were able to keep up to date with their e-learning. However, in June, only 47% of staff were up to date with physical interventions training and 64% for security training. Managers had arranged more face to face sessions and figures have begun to improve. Courses were running at 50% of their usual capacity, meaning this will take some time.

Long stay or rehabilitation mental health wards for working age adults

During the Covid-19 outbreak, managers had not ensured bank staff kept up to date with their mandatory training, including e-learning. In June 2020, only 64% of bank staff were up to date with mandatory training and less than 75% were up to date in 15 of the 23 courses. However, the new registering manager was aware of this and had plans to address it. By 27 July, 76% of staff were up to date with mandatory training.

Managers reported incidents appropriately and conducted investigations where appropriate, liaising with safeguarding team, CQC and care co-ordinators. Managers were open and transparent in relation to incidents and took action following investigations.

Information management

Not all staff had access to the equipment and information technology needed to do their work as there were insufficient computers for all staff to access patient records consistently.

Agency staff did not have access to the hospital's computer system, including to patient records. Patient information was communicated to agency staff via handovers and printouts.

Staff made notifications to external bodies as needed. This included care co-ordinators, the local safeguarding team and the CQC.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff follow care plans at all times and keep patients safe from avoidable harm. [Regulation 12 (1) (2) (a) (b)]
- The provider must ensure that all multi-factorial falls assessments are completed and that actions recommended in the assessments are actioned and recorded. [Regulation 12 (2) (a) (b) and Regulation 17 (2) (c)]
- The provider should ensure that agency workers can access the hospital's computer system including access to patient records. [Regulation 17 (2) (c)]

Action the provider SHOULD take to improve

- The provider should ensure that airflow mattresses are inflated correctly at all times. [Regulation 12 (2) (e)]
- The provider should ensure that there are enough computers for staff to access patient records in a timely manner.[Regulation 15 (1) (f)]
- The provider should ensure that cleaning schedules are completed for cleaning all ward areas and that infection prevention and control audits review these records regularly and address any concerns identified. [Regulation 17 (1) (2) (a) (b)]
- The provider should ensure there is an effective system in place to ensure that all staff feel able and confident to raise concerns. [Regulation 17 (1) (2) (a) (e) (f)]
- The provider should review their system for gaining feedback from staff and ensure staff feel supported. [Regulation 18 (2) (a)]

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

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