Cygnet Hospital Bierley

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Not sufficient evidence to rate

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Bierley as good overall, we were unable to re-rate the service overall as we did not carry out an inspection including all of our key lines of enquiry. However, during this inspection, we found breaches of regulation in all domains other than caring and responsive. Due to this, we have suspended the ratings of good in the effective and well–led domains.

- Following our inspection in August 2016, we rated the service as good for caring. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.
- We also rated responsive as good at the last inspection but we received information prior to this inspection in May 2017 raising concerns related to levels of activity and discharge planning. However, at this inspection we found that patients accessed a range of activities throughout the week, including weekends, and the services continued to discharge patients following discharge planning.
- The service had addressed the specific issues that had caused us to rate safe as requires improvement following the August 2016 inspection. All wards were clean and furniture had been replaced on Bowling ward (female specialist personality disorder service). Patients told us that staff always kept the hospital clean. The service was now meeting regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014: premises and equipment. The provider had created a system of mapping ligature points to reduce the risk to patients and increase staff awareness. The system was working well and staff were aware of the risk and mitigated it via observations.
- There was a range of rooms where patients could take part in activities such as art therapy, using the gym, computers, outside activities and therapy sessions. Wards and communal areas contained information for patients. Patients told us that they knew how to complain and that staff took their concerns seriously when they raised an issue. This had improved following the actions we reported the provider should improve at our visit in August 2016.
- Patients told us that ward rounds were more consistent and this was an improvement following our recommendation at our visit in August 2016.
- The provider had conducted a corporate risk assessment following guidance from the resuscitation council UK which mitigated the requirement for keeping the reversing agent with emergency drugs and so had addressed the action recommended at the last inspection in August 2016.
- The service had begun work on building a specific spiritual room for patients (as recommended at our inspection in August 2016). Patients and staff were involved in the planning and design of the room.

However:

- Despite the work by the provider to risk assess, eliminate and mitigate ligature points, this location remained in breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014: safe care and treatment. Staff carried out seclusion and rapid tranquilisation with patients and they did not always ensure they had done this safely. We reviewed specific episodes of both interventions and found that physical health observations were not always completed and recorded as per the provider's own policy. This increased the risk of harm to patients and on one occasion had resulted in a serious incident. The providers own governance system had not identified this issue.
- Although we did not receive information prior to this inspection in order to change the rating of 'good' in the well-led domain, during this inspection we found that systems and processes were not operating effectively or sufficiently embedded to ensure the service was safe.
- Staff had not always updated patient risk assessments after a significant incident of harm.
- The service had a high turnover of staff at 31% at the end of December 2016, but at the time of inspection this was 13%. This had led to a vacancy rate of 46% of nursing staff and 17% of healthcare support workers. This had caused significant use of bank and agency staff.

Summary of findings

- Staff did not adhere to internal policies and procedures and did not follow the Mental Health Act Code of Practice when using restrictive practices with patients.

Summary of findings

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Good

Cygnet Hospital Bierley

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; specialist personality disorder services.

Summary of this inspection

Background to Cygnet Hospital Bierley

Cygnet Hospital Bierley has been registered with the Care Quality Commission since 2010 to carry out the following regulated activities:

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

A registered manager was in place at the location. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

An accountable officer was also in place. The accountable officer is a senior manager who is responsible and accountable for the supervision management and use of controlled drugs.

Cygnet Hospital Bierley is a 63 bed purpose built hospital catering for men and women with severe and complex mental health needs. There are four single sex wards as follows:

- Bronte ward (forensic low secure female service): provides a 12 bedded forensic low secure service for women. At the time of the inspection, 10 patients were admitted and all detained under the Mental Health Act.
- Shelley ward (low secure male service): provides a 16 bedded forensic low secure service for men. At the time of the inspection, 16 patients were admitted and all detained under the Mental Health Act.
- Denholme ward (psychiatric intensive care unit): provides a 15 bedded psychiatric intensive care unit for women. At the time of the inspection, the hospital had admitted 10 patients all detained under the Mental Health Act.
- Bowling ward (female specialist personality disorder service): provides a 20 bedded specialist personality disorder service for women (16 beds on the ward, and 4 beds provided in a 'step down' annexe). At the time of the inspection, 17 patients were admitted to the ward, 16 were detained under the Act and one patient was an informal patient.

When the CQC inspected the location in August 2016, we found two breaches of regulation. We issued the provider with two requirement notices. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014: Premises and equipment.

Our inspection team

The team leader for the inspection was Gemma Berry, Inspector, Care Quality Commission.

The team that inspected the service comprised two Care Quality Commission inspectors including the team leader, and one assistant inspector.

Why we carried out this inspection

We carried out this short notice announced focussed inspection to find out whether the provider had made improvements to its services since our last inspection of the hospital in August 2016.

At our last inspection in August 2016 we rated the hospital location as good overall. We rated the service as good for effective, caring, responsive and well-led and requires improvement for safe.

Summary of this inspection

Following the August 2016 inspection we told the provider that it must take the following actions to improve the services:

- The provider must ensure that they identify ligature risks, recorded them on ligature risk registers and actions are put in place to ensure these risks are mitigated.
- The provider must ensure that they replace furniture on Bowling ward (female specialist personality disorder service).

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014: Safe Care and Treatment
- Regulation 15 HSCA (RA) Regulations 2014: Premises and Equipment

The provider sent us an action plan setting out the steps they were taking to meet the legal requirements of the regulations. We reviewed these breaches of regulation at this inspection.

Following the August 2016 inspection, we also recommended that the provider should take the following action to improve the service:

- The hospital should discuss and assess the emergency medicines and equipment required on each ward including the use of rapid tranquilisation medication and the reversing agent.
- The provider should ensure that the multidisciplinary team review and seek pharmacist advice when developing individualised pharmacological strategies for the short-term management of violence or aggression.
- The provider should ensure that they carry out maintenance works to areas of the hospital, which require improvement and redecoration.
- The provider should ensure that a room is available for patients which meets their spiritual needs.
- The provider should continue in its efforts to improve information available to patients before and during admission.
- The provider should ensure that on Bowling ward (female specialist personality disorder service), the timing of the ward rounds are consistent.

We reviewed whether the provider had followed these recommendations at this inspection.

As part of this inspection we considered information we had received raising concerns about the safety of the service in relation to incidents, staffing, and the seclusion facilities at the hospital, as well as issues raised at a visit by our Mental Health Act reviewer in January 2017. The Mental Health Act reviewer reported that there were issues with the safety of the seclusion room on Denholme ward (psychiatric intensive care unit) due to an issue with door following damage by a patient. This and previous Mental Health Act Review reports (December and November 2015) reported concerns relating to discharge planning on all wards except Shelley ward (forensic low secure male service), and lack of activity on Bronte ward (forensic low secure female service) and Bowling ward (female specialist personality disorder service).

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, we reviewed information that we held about the services at this hospital. This information suggested that the ratings of good for effective, caring, and well-led made following our August 2016 inspection, were still valid prior to completing this inspection.

Since the last inspection we received information raising concerns about the safety of the service relating to staffing, mandatory training, seclusion and incidents.

Summary of this inspection

Therefore, at this inspection, we reviewed the whole of the safe domain on order to review these concerns and to focus on those issues that had caused us to rate the service as requires improvement for safe. We also reviewed the actions we recommended that the provider should take following the August 2016 to improve the safety of the service. However we found breaches of regulation in the effective and well-led domains which have led to us suspending the rating for these key lines of enquiry.

We received information from the Mental Health Act monitoring visits regarding discharge planning and activities prior to this inspection. Therefore we reviewed the responsive domain in order to focus on these issues, as well as the actions we had recommended the provider should take following our inspection in August 2016 to improve the responsiveness of the service.

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 seven patients who were using the service
- spoke with two carers or relatives of people using the service
- spoke with the registered manager, quality lead, clinical lead and managers or acting managers for each of the wards
- spoke with three other staff members
- sought feedback about the service from care co-ordinators or commissioners
- sought feedback from an independent advocate
- Looked at 23 care and treatment records of patients
- carried out a specific check of the use of as required medication on all wards
- 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 seven patients using the service during the inspection who represented each of the four wards at the hospital. We also received feedback from the relatives of two patients using the service.

The patients were positive about the staff that supported them; they told us that they were 'great' and 'worked hard'. Patients were positive about community meetings and told us that they felt listened to when they reported concerns. They were happy to attend multi-disciplinary meetings, which had become more organised and consistent. The patients said that the hospital was very clean.

Both the relatives told us that the environment was clean and well maintained; there was a wide range of activities available. They also said that the doctors were responsive and that they were able to contact the wards whenever they needed to and always received a response from staff.

However, three patients raised concerns with us about restraint (on Bowling - personality disorder service, and Bronte - forensic low secure female service). They felt that some staff were too quick to use restraint as an intervention, too many staff were involved, and this had caused trauma for some patients, particularly when staff used prone restraint.

The other main concern of four patients was that the Bronte, Shelley and Bowling wards were sometimes short staffed. This meant that sometimes leave was cancelled and one patient complained about being taken to a hospital appointment with an agency worker who was unaware of their condition and had not met them before. One relative told us that they had known leave to be cancelled due to staffing shortages

In addition, whilst one of the two relatives we spoke with told us they were not involved in care planning, the service had invited them to meetings to discuss the progress and treatment of their relative.

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 carried out seclusion and rapid tranquilisation with patients. We reviewed specific episodes and found that physical health observations following both interventions was not completed and recorded as per the provider's own policy. This increased the risk of harm to patients and on one occasion had resulted in a serious incident. The providers own governance system had not identified this issue.
- Staff did not always update patient risk assessments following an incident of harm to themselves, staff or other patients.
- There was damage to the floor in the Denholme seclusion room which posed an infection control risk because it could not be thoroughly cleaned.
- Patients were not involved in discussions around restraint, and how they would prefer staff to restrain them through individual care planning.
- Staff did not always complete and record debriefs with patients after an incident.

However:

- During this most recent inspection, we found that the service had addressed the breaches of regulation that had caused us to rate safe as requires improvement following the August 2016 inspection. All wards were clean and the provider had replaced the furniture on Bowling ward (female specialist personality disorder service). Patients told us that staff always kept the hospital clean. The provider had created a system of mapping ligature points to reduce the risk to patients and increase staff awareness. The system was working well and staff were aware of the risk and mitigated it via observations.
- Each ward had a well-equipped clinic room where staff monitored and recorded fridge and room temperatures. Staff kept medicines and health equipment in good order and regularly tested it.
- The service was part of a provider wide reducing restrictive interventions programme, and we saw a positive trend in the reduction of restraint.
- The management team had drawn up a plan to reduce the amount of agency staff used on the wards, and had added concerns about staffing to the service risk register.

Summary of this inspection

Are services effective?

Not sufficient evidence to rate

At the last inspection in August 2016 we rated effective as **good.** During this inspection we found a breach of regulation so have suspended the rating in effective.

- Staff did not adhere to the Mental Health Code of Practice when carrying out restrictive interventions with patients. Seclusion was not recorded in the appropriate manner by nursing and support staff. Staff recordings did not evidence that restrictive interventions such as prone restraint were used for the shortest time possible and this meant that staff did not follow national guidance designed to protect patients.

Are services caring?

Good

At the last inspection in August 2016 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive?

Good

We rated responsive as **good** because:

- There was a range of rooms where patients could take part in activities such as art therapy, using the gym, computers, outside activities and therapy sessions. These areas of the hospital were in a good state of repair and personalised by the patients. This had improved following our recommendation at our visit in August 2016.
- Wards and communal areas contained information for patients about their treatment, advocacy, how to complain and how to contact the Care Quality Commission. Patients told us that they knew how to complain and that staff took their concerns seriously when they raised an issue.
- Ward rounds were more consistent and this was an improvement following our recommendation at our visit in August 2016.
- We made a recommendation in August 2016 that the provider should create a spiritual room for patients. Staff and patients told us that the project was on-going and both groups were working together to create an appropriate space.

Are services well-led?

Not sufficient evidence to rate

At the last inspection in August 2016, we rated well led as **good.** Prior to this inspection, we had received no information that would cause us to re-inspect this key question. However, during this

Summary of this inspection

inspection we found that systems and processes were not operating effectively or sufficiently embedded to ensure the service was safe. Because we found a breach of regulation we have suspended the rating in well-led.

- Audits of care records had not highlighted the issues around record keeping and staff kept documentation for seclusion in two places, which made it difficult to follow and review.
- Staff did not always follow the provider's internal policy and procedure or the Mental Health Code of Practice in relation to completing physical health interventions, observations and reviews as required for seclusion or rapid tranquilisation.
- The system the provider used to record and report incidents did not assist the staff to record clearly and consistently.
- Mangers had discussed the higher level of prone restraint in governance meetings but we saw no action plans for their reduction, and no reviews of the interventions. The recording of staff did not follow national guidance or the provider's own policy when they had undertaken these interventions.
- The service had a high turnover of staff at 31% at the end of December 2016, but at the time of inspection this was 13%. This had led to a vacancy rate of 46% of nursing staff and 17% of healthcare support workers. This had caused significant use of bank and agency staff.

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.

All wards at the service admitted patients who were detained under the Mental Health Act. We did not carry out a review of all the provider's responsibilities under the Act during this inspection. However we had concerns regarding the application of the Act in relation to the appropriate use of restrictive practices with patients such as seclusion, restraint and rapid tranquilisation. Staff did not always follow the guidance and principles of the Act.

Good

Location

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

Is the location safe?

Requires improvement

Safe and clean environment

We visited all four wards at the hospital to assess whether they were safe and clean. At our inspection in August 2016 we identified issues with cleanliness on Bowling ward (female specialist personality disorder service) and made a recommendation about improvements and redecoration to the shared areas and entrances of the hospital. At this inspection, we found that all wards were clean; patients told us that the wards were clean and cleaners were on site regularly. In house domestic staff cleaned the ward daily and in-house maintenance completed any repairs. The décor was well maintained and furniture was clean. However the seclusion room on Denholme ward had damaged flooring which would make the floor difficult to clean and this may pose an infection control risk to patients.

At our inspection in August 2016, we told the provider that it must ensure that all ligature points (a ligature point is something that a patient intent on self-harm could use to tie something to in order to strangle themselves) were included in risk registers to ensure risk of harm could be appropriately mitigated. At this inspection, although all wards continued to contain ligature points, the provider had put into place actions to mitigate the risks.

The wards had several ligature points in both patient bedrooms and communal areas, such as wardrobe doors and door closers on the corridors. On each ward we saw a large board in the staff office which contained a ligature map. This map highlighted all ligature points on the ward via a visual display which could only be seen by staff using the office. When we spoke with staff, they told us that they knew where this was and found it helpful in managing patient risk.

All wards had an 'L' shaped layout which did not allow staff a clear line of sight to observe patients. The provider mitigated this risk by allocating one staff member during all shifts to observe patients throughout the day and night. The level of observation for each patient was dependant on their risk level and could change accordingly. Staff recorded the level of observation required for each patient clearly on a board in the staff office to increase awareness of risk.

All four wards in the hospital were compliant with the Department of Health eliminating mixed sex accommodation guidance and the same sex accommodation guidance within the Mental Health Act Code of Practice.

All four wards had a fully equipped clinic room and all were clean with accessible and well-organised equipment. Oxygen was available, along with an examination couch, blood pressure machine, and weighing scales to allow staff to undertake physical examinations and procedures such as taking blood samples. All of the equipment used was clean and staff had calibrated it and checked it worked. Staff monitored the temperature of the clinic rooms and medicines refrigerators on a daily basis and kept up to date records of this, staff reported any errors to the hospital maintenance team. Staff ensured that they kept controlled drugs safely by locking them inside a box within a locked cupboard.

Good

Location

All wards had an emergency resuscitation bag, kept in the staff office (accessible to all staff) which contained oxygen, an 'Epipen', a defibrillator, ligature cutters, a first aid kit, and other equipment required for resuscitation. All equipment was in date and staff checked the bag on a weekly basis. Staff had access to hand gel cleansers, which were available in toilets and the clinic room.

All staff carried appropriate alarms. Each day the shift leader allocated a staff member to be the 'responder'. This team member was the first to respond to any incidents and any sounding alarms. Staff told us that there had never been a problem with the alarm system.

Only Denholme ward (psychiatric intensive care unit and Shelley ward (male forensic low secure) had seclusion rooms. Ward managers from Bronte ward (forensic low secure female service) and Bowling ward (female specialist personality disorder service) told us that should a patient require support in seclusion, they would use the seclusion room on the other two wards

Both the seclusion room on Shelley ward (low secure male service) and the seclusion room on Denholme ward (psychiatric intensive care unit) were fit for purpose and complied with guidance in the Mental Health Act Code of Practice. The rooms allowed observation via a viewing panel. A working clock was available in both rooms, which the patient could see and toilet facilities were available. The patient and observing staff were able to have two-way communication via an intercom when a patient was in seclusion. The rooms contained a mattress designed to be kept on the floor and had access to natural light. The seclusion room on Denholme ward (psychiatric intensive care unit) had scratched flooring which was unsightly and made the floor difficult to clean, this posed an infection risk to patients using this room. Patients on both wards had access to anti-rip gowns.

Bronte and Shelley wards (forensic low secure services) met with criteria for low secure forensic services as the entrances had an air lock system and a perimeter fence which was the appropriate height for the service.

Safe staffing

The leadership team included a hospital manager (registered manager), who was supported by a clinical lead, and a clinical quality and compliance lead. Each ward then had a manager, two clinical team leaders, and a staff team of nurses and healthcare support workers.

The wards used a 'patient acuity' staffing tool to identify staffing needs. Ward managers were able to increase staffing according to patient need. Low levels of permanent staffing were an issue across all wards. Of 37 nursing posts across the service, 17 were vacant (46%). Of 58 healthcare support worker posts across the service, 10 were vacant (17%). The hospital continued to recruit staff with five nurses currently in pre-employment check stage of the recruitment process. The service attributed staffing difficulties to a significant staff turnover rate of 31% at the end of 2016 (13% to May 2017), and a 3.7% sickness rate across the service.

The staffing establishment levels differed per ward due to the difference in complexity and number of patients. The hospital used bank and agency staff to fill shifts to the service's own recommended safe staffing levels. The service told us that between 1 January 2017 and 31 March 2017 no shifts on any wards were unfilled to the service's levels of staff staffing despite the significant number of staff vacancies. However, the staffing tool used by the service did not calculate staffing numbers against patient acuity on all shifts during this time period.

- Bronte ward (forensic low secure female service) had an establishment of eight full time equivalent nursing posts, two of these (25%) of the posts were vacant at the time of inspection. The ward had 10 full time equivalent healthcare support worker posts; three of these posts were vacant at the time of inspection (30%). During 1 January 2017 and 31 March 2017, the service used agency staff on 14% of shifts.
- Bowling ward (female specialist personality disorder service) had an establishment of twelve full time equivalent nursing posts, eight of these (67%) of the posts were vacant at the time of inspection. The ward had 18 full time equivalent healthcare support worker posts; three of these posts were vacant at the time of inspection (17%). During 1 January 2017 and 31 March 2017, the service used agency staff on 25% of shifts.
- Denholme ward (psychiatric intensive care unit) had an establishment of ten full time equivalent nursing posts; four of these posts (40%) were vacant at the time of inspection. The ward had 19 full time equivalent healthcare support worker posts; four of these posts were vacant at the time of our inspection (21%). During 1 January 2017 and 31 March 2017, the manager used agency staff on 31% of shifts.

- Shelley ward (forensic low secure male service) had an establishment of seven full time equivalent nursing posts; three of these (43%) were vacant at the time of inspection. The ward had 11 full time equivalent healthcare support worker posts none of these posts were vacant. During 1 January 2017 and 31 March 2017, the service used agency staff on 33% of shifts.

The hospital was aware of the use of agency staffing and the risk of vacant posts and managers had noted temporary staff use within the local risk register. The hospital had a number of ongoing recruitment programmes. The hospital manager explained that the agency staff were well known within the hospital and most worked shifts on a regular basis and had a key worker role with patients. Bank staff undertook the same level of mandatory training as permanent staff, and agency staff were trained by their employers. Senior managers had a good understanding of the impact that high vacancy rates and the high use of agency could have on patients and had an agency reduction plan in place. One patient told us that sometimes they worked with agency staff they did not know and reported that these staff had taken them to important appointments out of the hospital but could not support the patient well due to their lack of knowledge about them.

Patients and one carer told us that staff shortages were an issue; they told us that staff cancelled activities and leave sometimes due to staffing shortages. We asked the provider if they ever cancelled leave and activities due to staffing shortages but they did not collate this type of data at the time of the inspection. The service advised since the inspection that this data is now being collected and will be provided to commissioners of the service.

There was a multi-disciplinary team consisting of a consultant psychiatrist (0.5 full time equivalents per ward), one speciality doctor per ward, occupational therapists, occupational therapy assistants, psychologists and social workers. There was one part time social work post and one speciality doctor post vacant.

The hospital had on-call arrangements that met the needs of the service. Out of hours, there was always a nurse on call, and a clinical team leader or manager. There was a speciality doctor and psychiatric consultant rota covering both day and night. We saw in patient records that staff had contacted doctors out of hours and they responded quickly attending the hospital in person where necessary.

Staff working at the hospital completed mandatory training, which included risk management training so staff were aware of individual patient risks and the ligature points contained within the wards. The provider's compliance target for mandatory training was 95%. At the time of the inspection the hospital had achieved above 80% in all mandatory training modules.

Assessing and managing risk to patients and staff

Staff used the 'START' and 'HCR-20 (version three) risk assessment tools. All patients had a risk assessment completed within 24 hours of admission repeated at 72 hours. On each ward staff used several ways to monitor and measure risk such as using traffic light systems, changing observation levels and discussing patient needs in multi-disciplinary meetings. However, we found that staff did not always update risk assessments following a significant incident. In two of the 11 risk assessments we reviewed, the patient had self-harmed or assaulted staff or another patient. Whilst information about incidents was stored on incident forms and in patient notes, staff had not updated the risk assessment which meant that staff might not be aware of an increased risk.

Between 1 January 2017 and 31 March 2017 there were 18 incidents of seclusion. Denholme ward (psychiatric intensive care unit) had 16 incidents of seclusion and Bronte ward (forensic low secure female service) had two uses of seclusion. There were no incidents resulting in the use of seclusion on Shelley ward (male forensic low secure) or Bowling ward (female specialist personality disorder service).

We reviewed 11 seclusion records in detail. Staff had not recorded seclusion in an appropriate manner and did not always follow the provider's own policy in nine of these records. We saw evidence of three occasions where nurses did not carry out two hourly reviews and did not always counter-sign the records. This meant that the service was not ensuring the safety of patients whilst in seclusion by ensuring their physical and emotional health was reviewed by a qualified member of staff. We also found that there was no way to determine from the written seclusion records what designation the staff

member was, who was working with or reviewing the patient because the recording was an unclear signature on the form. The service told us that this information could be found by checking staffing rotas. However this meant that the information was not clearly and readily available to staff including temporary or new staff at the change of a shift.

In seven records, observations of the patient in seclusion did not take place or observing staff had not recorded them every 15 minutes as required. One patient had alleged to have swallowed an object by telling staff they had done so. This patient then vomited but staff carried out no medical checks other than calling the doctor. It was unclear whether staff had carried out appropriate searching procedures with this patient before they entered seclusion as this was not recorded. Another patient had constructed a weapon whilst in seclusion and the recording of the observation of the patient was not clear.

Seclusion documentation was stored in two different places. Staff kept their observations with the patients' daily record, while nursing staff and doctor recorded them on an incident form. This meant that information was difficult to follow because the provider did not keep it in one place.

The hospital reported that there had been no incidents of long-term segregation.

Between 1 January 2017 and 31 March 2017 there were 98 episodes of restraint at the hospital. The hospital provided a breakdown of the use of restraint within the period which showed that;

- Denholme ward (female psychiatric intensive care unit) had 48 incidents of restraint (14 of those were prone restraint)
- Bowling ward (female specialist personality disorder service) had 31 incidents of restraint (nine of those were prone restraint)
- Bronte ward (female forensic low secure) had 17 incidents of restraint (three of those were prone restraint)
- Shelley ward (low secure male service) had four incidents of restraint (one of those was prone restraint).

National Institute for Health and Care Excellence guidance NG10 (violence and aggression) recommends avoiding prone restraint, and only using it for the shortest possible time if needed. The Mental Health Act Code of Practice (2015) contained within the provider's own policy states that "unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor." Prone restraint is holding a person chest down, whether the patient placed himself or herself in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes staff placing the patient on a mattress face down while in holds, administration of depot medication while in holds, and being placed prone onto any surface. Prone restraint carries a high risk of asphyxiation to patients and services have reported a number of deaths. Therefore, we found it concerning 27 incidents restraint between 1 January 2017 and 31 March 2017 were in the prone position, and that in nine of the patient records we reviewed, staff had recorded five of these prone restraint episodes as lasting for five minutes or longer. There was no cogent reason recorded as to the length of time for these restraints, or why they had been carried out in a prone position. The provider's own policy 'promoting safe and therapeutic services' states that "staff should record the reasons for physical restraint, including details about how the intervention was implemented and the patient's response in accordance with the policy for patient safety: Incident reporting and management".

We spoke with three patients on Bowling (specialist female personality disorder service) and Bronte (forensic female low secure service) who told us that staff were quick to use restraint as a first rather than a last resort. These patients told us that staff restraining them in this manner brought back past trauma and they felt that it would be helpful for the hospital to have restraint plans or advance statements about restraint in place to reduce distress.

We also had concerns about the way staff had recorded episodes of prone restraint. Staff recording was not detailed. For example, it stated that prone restraint lasted five minutes or longer, with no specific reason as to why prone rather than another restraint technique was used, there was no recording of what de-escalation techniques were used to ensure restraint was a last resort.

During the inspection, we asked the senior leadership team about the use of prone restraint, they were not

immediately aware of; numbers of prone restraint, the numbers of prone restraints for extended periods, and the poor recording of prone restraint. However, they told us that all episodes of prone restraint were reviewed using the CCTV system at the service and that each individual ward had an action plan in place to review restrictive interventions. They explained that reducing restrictive practices were a priority across Cygnet Healthcare, with a restrictive practice board and a reducing restrictive practice network in place, which the hospital was a part of with two staff representatives. However when we reviewed a governance meeting presentation we saw that prone restraint had been highlighted for discussion, however there was no action plan for the significant level of prone restraint used and no evidence of how this was joined up with the individual ward management plans. This meant that a high-risk intervention was being used to a significant amount by staff, which the management of the service had not acted upon and actioned in a timely manner because they were unaware of the issue in its entirety.

The service continued to review blanket restrictions within its reducing restrictive practice programme. We saw that whilst there remained some restrictions in place on the wards such as; laundry rooms, kitchens activity rooms and clinic rooms being locked, and outside access required supervision. The hospital had balanced these restrictions with the needs and risks of the service user group.

Informal patients were able to leave the hospital at will; those patients who the service had admitted informally carried a pink identification badge to let staff know that they were able to leave independently. The hospital allowed patients to have their own mobile phones and laptop computers unless staff had identified a specific risk.

We reviewed episodes of rapid tranquilisation because at our inspection in August 2016 we recommended that the provider reviewed its requirement for the stock of the reversing agent for Lorazepam injections for rapid tranquilisation. The provider had conducted a corporate risk assessment following guidance from the resuscitation council UK which mitigated the requirement for keeping the reversing agent with emergency drugs. Whilst the provider had addressed this recommended action, we found further concerns relating to the use of rapid tranquilisation.

Rapid tranquilisation is when staff give medicines to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need.

The hospital used rapid tranquilisation on 50 occasions between 1 January 2017 and 31 March 2017. There were 20 episodes of oral rapid tranquilisation and 30 episodes of intra muscular procedures:

Bronte ward (forensic low secure female service): 14 rapid tranquilisation episodes, four of these were intra muscular.

Denholme ward (psychiatric intensive care unit): 24 rapid tranquilisation episodes, 18 of these were intra muscular

Bowling (female specialist personality disorder service): 11 rapid tranquilisation episodes, seven of these were intra muscular

Shelley (male forensic low secure): one episode of rapid tranquilisation, which was intra muscular.

We reviewed 14 of these episodes in detail and four episodes contained errors, which may lead to significant harm to patients. Where staff had recorded rapid tranquilisation there was no evidence within the rapid tranquilisation record of who had given the medicines, the staff members designation (the recording of this was an unclear signature) or where staff had administered them in the patient's body. This meant that managers and staff could not undertake immediate checks to review episodes and ensure staff were appropriately administering medication without checking signatures on the prescription card and staff rota, to find the records indicating which staff were involved. This record was kept away from the rapid tranquilisation record itself.

We also found that staff had failed to carry out the appropriate checks on patients following the use of rapid tranquilisation in two of the records we reviewed.

Staff had given one patient rapid tranquilisation via an intra muscular route, there was only one health check recorded one hour after the episode and then the

following morning fifteen hours after the episode. This patient's records also showed that a second medicine had been given to them. Staff did not take into account the additional risk associated with giving the patient two doses of different medicines. In another record, staff had given rapid tranquilisation and the patient had one health check fifteen minutes after the episode where staff recorded a high pulse rate but did not undertake further checks. This was not in line with the provider's own policy which states "side effects should be monitored; the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness should be monitored at least every hour until there are no further concerns about their physical health status. Monitoring should occur every 15 minutes if the maximum dose has been exceeded or the service user appears to be asleep or sedated, has taken illicit drugs or alcohol, has a pre-existing physical health problem has experienced any harm as a result of any restrictive intervention." It is important that such checks are undertaken to reduce risk to the patient who may experience over sedation, loss of conscious, allergic reaction or cardiac arrest.

We reviewed the use of as required medications because at our inspection in August 2016 we recommended that staff sought pharmacy support for individual care planning to guide the use of as required medication. We reviewed the medication records of eight patients (two per ward). We saw evidence of the involvement of pharmacists in the care plans written by the staff. The pharmacist also completed a side effects review chart in each medication file to monitor any adverse medication affects and completed a weekly audit and review of all prescriptions. Medication cards were in good order. Ward staff also reviewed medication cards twice daily at handover.

Staff told us that pharmacy advice was available by telephone every day until 10pm at night which staff tended to use for advice. The pharmacist was on site weekly to provide face-to-face advice as required.

The provider had therefore completed this recommended action from the last inspection.

Track record on safety

The hospital had reported five serious incidents between 01 April 2016 and 01 May 2017. Two of these incidents occurred on Bowling ward (female specialist personality disorder service) and three on Denholme ward (female psychiatric intensive care unit). The incidents related to one episode of missing medication from the clinic room, one episode of a patient accidental overdose, one episode of a patient's detention under the Mental Health Act, which staff had not renewed in time, and two episodes of patients making safeguarding allegations against staff members.

Managers completed a root cause analysis following each incident. The outcome of these were discussed in monthly governance meetings. Lessons learned were then shared with the ward managers, who was responsible for sharing this learning with staff in handovers, team meetings and supervision. We reviewed one incident, which showed that the service had identified a medication error and the lessons and recommendations from this had been shared provider wide to prevent reoccurrence.

There have been no patient deaths at the service since August 2016. The service continued to be involved in the review of three deaths (pre August 2016) with the clinical commissioning group. The Cygnet wide patient safety committee reviewed every death reported within the hospital and the managers used root cause analysis to carry out investigations. It was felt that these deaths had raised the profile of good physical health intervention and due to this, the service had plans to increase physical health reviews for all patients.

Reporting incidents and learning from when things go wrong

In the period 1 January 2017 and 31 March 2017, there were 96 incidents on Bronte ward (forensic low secure female service) 149 incidents on Denholme ward (female psychiatric intensive care unit), 184 incidents on Bowling ward (female specialist personality disorder service) and 49 incidents on Shelley ward (low secure male service).

All staff, including those who were temporary staff were able to report incidents, using a paper record and reporting them verbally to the nurse in charge. These were incidents such as self-harm, restraint, and incidents between patients and towards staff. Staff recorded incidents on paper forms, and they kept them separately from the main patient file until an electronic copy was made available and placed within the patient's clinical

record. We saw that the information stored in different places was not always consistent. It also made the detail difficult to corroborate and review when looking at an incident to obtain a theme or trend and provide lessons for staff. This meant that the systems for reporting incidents to ensure safety and quality were not always effective. We saw evidence of this because the service's internal systems had not picked up on the concerns regarding recording during our inspection. However the hospital manager told us that the service was in the process of implementing ward manager reports to further strengthen the ownership of risk management at a ward level and identify trends and themes.

The hospital had a governance structure in place to allow the ongoing review of safety. Each morning the clinical lead met with the ward managers to review all incident forms from the previous day. The clinical lead then reviewed any significant or serious incidents in detail including the viewing the close circuit television and followed up any actions. Senior staff completed a fact finding report within 24 and 72 hours of a serious incident, and then made a decision whether a root cause analysis was appropriate to aid future learning.

The clinical lead would pass a significant incident with learning for staff to the corporate risk manager who would allocate an external reviewer from another hospital within the provider's organisation. This allowed a more independent review of the incident which would be shared with the service.

Senior members of the team carried out root cause analysis on serious incidents and they shared findings at monthly governance meetings. All hospitals in the local area and the area quality manager attended these monthly governance meetings. This allowed staff to share and explore learning and themes from incidents. The provider had increased the number of staff who had training in root cause analysis, this had included doctors and psychologists to provide a multidisciplinary approach to incident analysis.

Staff told us that following an incident, debriefs took place to support them to reflect on the incident and learn lessons to improve practice. Staff offered patients debriefs with a specific form in a one to one session. However debriefs were not always recorded on the incident forms as required, including in the 11 seclusion records we reviewed and two other incidents where we saw no evidence that a one to one debrief had taken place.

Staff were able to give examples of how things had changed following an adverse event, for example changing equipment across the hospital following a patient using it as a ligature.

Duty of Candour

Providers of healthcare services have a duty to be open, honest and transparent with patients and their families when things go wrong with care and treatment. This duty involves providing support.

The provider had a policy in place to inform staff about their responsibilities. We spoke with three members of staff during the inspection who were aware of their need to be open and honest. All three staff could give examples of times when they needed to explain to patients when things had gone wrong. Senior managers were aware of the policy in place and could give examples of times when they had used Duty of candour with patients and understood the need to follow this up in writing.

Is the location effective?
(for example, treatment is effective)

Not sufficient evidence to rate

At the last inspection in August 2016 we rated effective as **good.** During this inspection we found a breach of regulation so have suspended the rating in effective.

Adherence to the Mental Health Act and Mental Health Act Code of Practice

The service admitted patients to all wards who were detained under the Mental Health Act. Staff should follow the Mental Health Act Code of Practice when working with all detained patients to ensure their rights are upheld. We had concerns during this inspection that staff were not following the principles of the Act.

When staff used seclusion with patients, nurses did not always carry out and record two hourly reviews of the patient and did not always counter sign the records. We saw this in three of the 11 records we reviewed. The

Good

Location

Mental Health Act Code of Practice states that nurses must carry out reviews every two hours, and they must record the patient's condition and the nurses' recommendations. Where this does not take place, the patient is not adequately protected from harm and do not have their rights upheld.

Department of Health guidance 'Positive and Proactive Care' (2015) states that if a restrictive intervention is used, it must always represent the least restrictive option to meet immediate need. During the inspection we saw that this was not the case because staff had not kept seclusion episodes to the shortest time possible. Seclusion records stated patients were 'settled' but there remained gaps of significant time before staff permitted them to leave seclusion with no recorded justification. We reviewed the record of one patient who staff reported as settled and sleeping. A doctor and a nurse reviewed the patient and the patient remained in seclusion with no written justification for this. There were no further incidents with this patient but they remained in seclusion for a further eight hours and fifteen minutes.

During the inspection, we reviewed episodes of prone (chest down) restraint, because we saw that this high-risk intervention had been used on 27 occasions by staff between 01 January 2017 and 31 March 2017. National Institute for Health and Care Excellence guidance NG10 (violence and aggression) recommends avoiding prone restraint, and only using it for the shortest possible time if needed. The Mental Health Act Code of Practice (2015) contained within the provider's own policy states that "unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor." Prone restraint is holding a person chest down, whether the patient placed himself or herself in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes staff placing the patient on a mattress face down while in holds, administration of depot medication while in holds, and being placed prone onto any surface. We found that staff had not recorded a cogent reason for the use of this type of restraint, and three patients told us that were worried about its use. Staff had also reported that these restraints lasted five minutes. This is not the shortest time possible and therefore not in line with the principles of the Act.

Despite it being embedded within the provider's own policy and procedures, staff practice evidenced a lack of understanding of the Act, the Code of Practice and their guiding principles when they worked with detained patients.

We were also concerned that the provider had not repaired the floor in the seclusion room on Denholme ward. This was an infection risk as the damage prevented the floor from being appropriately cleaned. A concern in relation to the door in the same seclusion suite was raised by our Mental Health Act Reviewer in 2017

Is the location caring?

Good

At the last inspection in August 2016 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Is the location responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

At our inspection in August 2016, we recommended that the provider should make information about admission to the service more accessible to new patients and their families.

At this inspection patients told us that they enjoyed weekly ward community meetings where they could ask questions and get information. Patients on Denholme ward (female psychiatric intensive care unit) took part in daily morning meetings were they discussed activities, leave and any other ward matters, which they found positive. We requested copies of the patient and carer information leaflets made available to people admitted to the service and saw copies of the leaflets available on Shelley ward (forensic low secure male service) and Bronte ward (forensic low secure female service). The provider told us that these leaflets were available relating

specifically to all wards. There had been improvements regarding the accessibility of the information about admission following our recommendations at the last inspection.

The average length of stay on Denholme ward (female psychiatric intensive care unit) was 51 days, 18 months on Shelley ward (male forensic low secure), 15 months on Bowling ward (female specialist personality disorder service) and 12 months on Bronte ward (forensic low secure female service). Patients on Shelley ward (male forensic low secure) had the longest length of stay with one patient admitted six years ago.

We reviewed the number of discharges at this location following information from the Mental Health Act monitoring visit in relation to discharge planning. The hospital continued to discharge patients on a regular basis and we saw that there was an improving picture of more frequent discharge from the service and fewer re-admissions in the last three years. The service had discharged 125 patients between 01 May 2016 and 30 April 2017 with only six re-admissions. Patients we spoke with told us that they had discharge plans, had been involved with them and had discussed long-term plans with staff.

Patients' beds remained allocated to them until discharge, including if they left the hospital for leave. The psychiatric intensive care unit was accessible to patients from other wards, if their needs increased and they required more intensive treatment.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a full range of rooms and equipment to support treatment and care. This included clinic rooms, quiet rooms and communal dining areas and lounges on each ward.

The hospital also had a shared accessible outdoor space with seating areas and outdoor games.

The hospital had various multi-purpose activity rooms for patients on the first floor including a gym, music room, one to one therapy rooms, IT room, and meeting rooms. Staff locked these spaces when not in use due to the risks associated with the equipment. There was also a sensory room available, which had softened walls, sensory lights and soft furnishings. Patients were encouraged to use the space to relax and deescalate. Drinks, snacks and activities were available for patients using the room.

Patients were able to meet visitors in specific visitors' rooms in the main hospital, and carers were able to visit the ward where appropriate.

Patients were able to make phone calls in private, as most patients had access to their own mobile phones. Where they did not, there were communal phones cited on the wards. Where these were not private enough staff supported patients to use to cordless phones from the staff offices.

Catering staff cooked food on site and delivered it to the wards in trolleys. We saw that menus were available to offer choice to patients and that the catering staff were able to provide food for specific needs and diets such as vegetarian, halal and vegan meals. However, three patients said that the food sometimes tasted bad, orders were sometimes muddled, and one patient told us that they didn't feel their dietary need due to a medical condition was being met (so they brought their own food onto the ward). These patients said that they did not feel that catering staff made changes when ward staff voiced their concerns about the food. However, to encourage independence, patients were able to use kitchens with staff support to cook their own meals, and communal areas had microwaves for patients to use. Patients had access to hot and cold drinks throughout the day and fruit was available for snacks. The wards kept stocks of foods such as noodles and sandwiches so that meals and snacks were always available to patients admitted outside catering hours or patients missing meals due to feeling unwell.

Patients were able to personalise their bedrooms, and we saw that patients were doing so on the longer stay wards. Patients were able to secure their possessions in a safe in their wardrobe should they wish too.

At a recent Mental Health Act monitoring visit, concerns were raised that Bronte (female low secure service) and Bowling ward (female specialist personality disorder service) lacked activity. Therefore, we reviewed the activities available to patients on all wards at this inspection. Patients had individual activity timetables, which ran through the week and at weekends, some

chose to keep them on display in their bedroom. We spoke with patients who were going on outings to horse riding and swimming during our visit. In addition to individual activities, patients were able to join activity groups, which ran across the hospital. When we spoke with patients five told us that individual timetables were good, and commented that the recovery college was 'great'. However, two patients felt like there was not enough on ward activity available but because much of it needed an escort. They said that because of staffing shortages patients could not always leave the wards or go into areas where they required higher levels of observation. These patients also told us that on ward activity sometimes was low, because there was not always enough staff to engage with people.

Meeting the needs of all people who use the service

At our inspection in August 2016 we recommended that the provider should have a spiritual room for patients to access. At this inspection, the provider had started a patient involvement project to design the space.

During the inspection, we visited all wards within the hospital and found that they all had information available to patients about treatment, different mental health conditions, the recovery star, how to contact advocacy, how to complain and how to contact the Care Quality Commission. The hospital did not display information in other languages but staff told us that they could gain access to this as required, although we did not see this during the inspection.

Listening to and learning from concerns and complaints

Between 01 January 2017 and 31 March 2017, the service received 11 complaints. Four of these related to the quality of care provided, two related to property, one to staff attitude and four marked as 'other'. Of these complaints, one was upheld, one partially upheld and one withdrawn, the remaining eight complaints were not upheld. No complaints were referred to the Ombudsman for further investigation.

In the same period, the service received 23 compliments, mainly relating to positive therapeutic interventions.

The service discussed complaints at the monthly governance meeting and the clinical lead investigated all complaints. For example after a serious incident involving equipment within the hospital, staff removed this equipment. Staff told us about this, making it clear that managers had made them aware of the changes needed following this incident.

Patients told us that they knew how to complain and told us that staff took complaints seriously and that they felt listened too. However patients did tell us that they raised repeated concerns about the food quality and did not feel that changes had been made in response to their concerns.

Is the location well-led?

Not sufficient evidence to rate

Good governance

At the last inspection in August 2016, we rated well led as good**.** Since that inspection, we had received no information that would cause us to re-inspect this key question. However, whilst we were inspecting the safety and responsiveness of the service at this inspection in May 2017, we identified that not all processes and systems were operating effectively or sufficiently embedded to ensure the service was safe. During this inspection we found a breach of regulation so have suspended the rating in well-led.

The systems and processes had failed to highlight a number of concerns regarding the safety of the service.

During the inspection we identified a number of issues with recording including; updating risk assessment plans, and recording seclusion, rapid tranquilisation, and prone restraint appropriately. Staff kept documentation for seclusion in two places, which made it difficult to follow and review. The provider told us that staff undertook monthly audits of patient documents, but these audits had failed to identify these concerns or ensure action was taken to address these.

Despite there being policies in the place we found that staff did not always follow the provider's internal policy and procedure or the Mental Health Act Code of Practice in relation to completing physical health interventions, observations and reviews as required for seclusion or rapid tranquilisation. The system the provider used to

record and report these incidents was poor and did not assist the staff to record clearly and consistently. Not all debriefs were recorded on the incident forms as required which had not been identified by the provider.

Although mangers had discussed the higher level of prone restraint in governance meetings, we saw no action plans for their reduction, and no reviews of the interventions or the recording of staff actions in these interventions. We discussed the high level of prone restraint with the senior leadership team responsible for reviewing these incidents and they were not immediately aware of the number of prone restraints which had taken place.

The service had a high turnover of staff at 31% at the end of December 2016, but at the time of inspection this was 13%. This had led to a vacancy rate of 46% of nursing staff and 17% of healthcare support workers. This had caused significant use of bank and agency staff.

However staff knew how to report incidents and patients felt confident in the management of complaints and concerns. The provider had systems in place which included a daily review of all incidents between the ward managers and the clinical lead. The manager told us that they reviewed incidents and complaints and then discussed data, themes and trends in monthly governance meetings. We saw evidence that this happened, and that the senior leadership team met on a regular basis with the provider wide quality lead. The service was working on a new system to support the analysis of this data to support practice.

Senior leaders reviewed the risk register in monthly governance meetings, and then again in more depth at a quarterly review with the corporate risk manager. Managers told us that they could add any significant risks raised to the local risk register and corporate risk register if necessary. The corporate risk register was reviewed six monthly at a board meeting. For example, the management team had identified staffing on the risk register and they had drawn up a plan to reduce the amount of agency staff used on the wards.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff complete the appropriate physical health checks with patients following the use of rapid tranquilisation and with patients in seclusion.
- The provider must ensure that systems and processes are operating effectively and embedded to ensure the service is safe.

Action the provider SHOULD take to improve

- The provider should ensure that the guiding principles of the Mental Health Act are understood by staff.
- The provider should discuss restraint with patients and request their input into how staff use restraint in individual care planning.
- The provider should ensure that staff update risk assessments after every significant incident to ensure they remain accurate.
- The provider should ensure the seclusion rooms are appropriately maintained and in a timely manner.
- The provider should ensure that patient and staff debriefs are completed and adequately recorded.

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 **How the regulation was not being met:** Staff had failed to provide care and treatment in a safe way. Because they did not carry out the appropriate physical health checks with patients following the use of restrictive interventions such as rapid tranquilisation and seclusion. Staff did not search patients appropriately before starting a seclusion process. **This was a breach of regulation 12 (1)**

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 **How the regulation was not being met:** Systems and processes were not operating effectively or embedded to ensure the service was safe. Staff did not follow internal policies and procedures and did not adhere to legislation such as the Mental Health Act Code of Practice in order to protect patients. The provider's own governance systems had failed to recognise these concerns. **This is a breach of regulation 17 (1) (2) (a) (b) (c)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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