Elysium Healthcare Limited

The Copse

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The Copse is a long stay, high dependency rehabilitation hospital that admits patients over the age of 18 with enduring mental health issues from acute inpatient services, to help them transition to living better lives in the community or in supported community placements.

The service was last inspected in July 2019 to follow up specific concerns in response to the previous comprehensive inspection in 2018 that highlighted a failure to comply with a number of the Health and Social Care Act Regulations (HSCA). We inspected the safe and well led key questions and found the provider had addressed all previously raised concerns and we rated the service good in all domains and overall.

We expect providers that deliver care and treatment to people within a long stay/rehabilitation service to be able to demonstrate how they meet the needs of patients in line with current guidance and best practice. We expect long stay/ rehabilitation services to provide safe care and treatment that is recovery focused, promotes independence and treats people who use the service with dignity and respect.

We carried out an unannounced, focused inspection of The Copse following concerns identified during engagement with the service. Other information of concern received via complaints, whistleblowing's and our 'share your experience' website option also informed our decision making. Concerns related to safe management of medications, incidents and issues relating to staffing.

We began our inspection on 10 August 2021. On 17 August, we returned to gather more information. However, on arrival on site, we made the decision to leave and allow the service to implement their management of suspected or confirmed Covid-19 outbreak effectively as required.

As we were unable to gather the information we required, the inspection activity was paused until a time where we were able to return and complete our inspection activities.

During the paused period, the provider updated us of changes they were making to the service and resources that were being implemented as a result of feedback we gave during our initial visit.

On 29 September, we carried out further reviews of care records via remote access at an alternative Elysium site. This was due to The Copse following Covid-19 outbreak protocols, which meant we couldn't go on site.

We returned to The Copse for our final visit on 12 October. During our visit, we further reviewed documentation that could only be conducted on-site.

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

- The service did not always provide safe care. During our inspection we found there were times when there was not enough staff on the wards to meet the needs of the patients. Wards were not always left with enough staff to meet the needs of the patients when responding to emergency calls for assistance. Staff were not always able to take breaks due to lack of sufficient cover available for them to leave the wards.

Summary of findings

- The ward environments were not always safe. The wards had blind spots that were partly mitigated by convex ceiling mirrors. However, there were not enough staff on the ward that were able to monitor patients and view blind spots via the mirrors.
- Staff and patients told us there was an over reliance on bank and agency staff which meant there were times when patients were not familiar with the staff providing their care. We were told by staff that occasionally agency staff did not turn up when they were expected to, which contributed to the service being short staffed.
- There was not always enough registered nursing staff available. During our initial visit, we saw there was only one registered nurse on duty that night. We reviewed previous night staff allocations and saw that there had been other recent occasions where only one registered nurse worked the night shift. The nurse was responsible for all medication administration across the four wards during the shift. We found eight occasions over the previous three months that the registered nurse administered controlled medication outside of company policy, without supervision and a signature from a second registered nurse. These administration errors coincided with times that only one registered nurse was on site. During these shifts, the registered nurse could not have a break for the whole shift or comfort breaks without leaving the wards without a qualified member of staff. Staff told us this was not an isolated occurrence.
- Staff did not implement robust systems and processes to safely administer and manage medicines. Medicine management audits were not always acted on in a timely manner by staff. Staff did not consistently follow national guidance and company policy to ensure correct administration of medication. Clinical staff did not ensure that patients who received high dose antipsychotics (cumulative or single doses of antipsychotics above British National Formulary recommendations) had care plans in place, and that the effectiveness and appropriateness of this medication was regularly reviewed.
- Staff did not assess or manage risk well. We reviewed care records and found that identified risks were not recorded properly and with appropriate management plans, which meant known risks and concerning behaviours were not safely mitigated. We saw no evidence of decision-making processes to substantiate the appropriateness of decisions being made. Disproportionate restrictions were placed on a patient that did not aid their recovery or promote wellbeing. The impact of this meant patients were at a risk of harm to themselves and others. Not all staff knew the location of emergency equipment. During our initial visit, a staff member was unable to identify where the emergency grab bag and defibrillator were kept.
- Reporting of incidents was not consistent. Staff did not report all incidents in a timely manner and had not reported some incidents to external agencies as required. The escalation of incident reporting allows providers to reflect and learn, this learning could then be shared across the organisation to improve safety, practice and outcomes for people who use the service.
- The service was not well led, leaders did not display clear oversight of the service. Staff we spoke to told us they were unsure of who held certain areas of responsibility. Monthly clinical governance meetings minutes lacked action plans to address all identified concerns.

However:

- The service made some improvements to documentation around risks and risk management plans following our initial inspection visit. Minutes of multi-disciplinary team meeting (MDT) were more detailed and included discussions around risks and included some rationale to decisions made.
- Further review of care plans following the initial visit showed that improvements had been made in response to the issues we had raised. Improvements included accurate identification of risks and management plans appropriate to meet the needs of the patient. Physical health needs, medication and food/fluid intake were comprehensively documented, personalised and up-to-date plans in place. Inappropriate restrictions that were previously placed on the patient were lifted and the rationale for other interventions were well documented.
- A further visit in October showed improvements had been made following a review by leaders within the service. The clinic room was clean, tidy and equipment stored appropriately.

Summary of findings

- The service had restructured the ward arrangements following feedback on the initial visit. They had employed an additional ward manager to provide more leadership capacity with the staff teams. Leadership structure and accountability was better established.
- Seven healthcare workers, two staff nurses and a deputy ward manager vacancy had been filled to reduce the number of bank and agency staff used following the inspection visits.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to The Copse

The Copse is an independent hospital, situated in Weston Super-Mare, North Somerset.

The hospital has 24 beds and is split into four, six bed wards, three for men and one for women.

The service is registered to provide the following regulated activities:

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

What people who use the service say

Patients told us there was not always enough staff. One patient said there was no-one to go to at night for help. Another patient said leave was rarely cancelled, but if so, short staffing was the reason.

Patients said they liked the food.

How we carried out this inspection

As this was a focused inspection, we only looked at the key lines of enquiry in the safe and well led domains. We asked the following questions of the service:

- Is it safe?
- Is it well led?

Before the inspection visit, we reviewed information that we hold about the location, including the previous inspection report, ongoing monitoring information and information from stakeholders.

During our inspection visits, the inspection team:

- visited all four 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 one carer
- spoke with 11 staff; including nurses, occupational therapy workers, healthcare support workers the hospital director and the regional operations manager
- attended and observed the morning handover meeting and looked at minutes from other handover meetings
- looked at 21 care and treatment records
- looked at incidents and safeguarding records
- carried out a specific check on medicines management in the service, including 12 medicine charts
- looked at a range of policies, procedures and other documents relating to the running of the service
- conducted an online survey available for all staff and received 18 responses
- spoke with members of external agencies, including the independent mental health advocate, pharmacist, and local authority safeguarding team.

Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure staff complete comprehensive risk assessments of patients and update this to reflect new and changing risks. (Regulation 12)
- The service must ensure that medicines are prescribed and administered accurately, and that patients prescribed high doses of medication have an associated care plan in place that is reviewed regularly. (Regulation 12)
- Managers must ensure that the use of restrictive interventions is monitored and reviewed to ensure these are proportionate, necessary and used only as a last resort. (Regulation 12)
- The service must ensure clinic equipment is cleaned and maintained and an auditable record is kept of this. (Regulation 12)
- The service must ensure all staff keep up to date with immediate life support training and are aware of the location of emergency equipment. (Regulation 12)
- The service must ensure that staff and managers recognise, report and respond to patient safety incidents. (Regulation 17)
- Managers must ensure that medicines management audits are reviewed in a timely manner and results escalated, and appropriate action taken. (Regulation 17)
- Staff must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. (Regulation 17)
- Managers must ensure that the service takes appropriate action to investigate and learn from safeguarding incidents and learning is shared with all staff. (Regulation 13)
- The service must ensure enough suitably qualified, competent and skilled staff are deployed to fully meet the needs of the people who use the service. (Regulation 18)

Action the service SHOULD take to improve:

- The service should ensure that all staff are familiar with the pharmacy audit system, so that timely action is taken in response to findings in the allocated nurse's absence.
- The service should ensure effective systems are in place to mitigate occasions where staffing levels become low at short notice.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Requires Improvement

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

Safe and clean environment

Although the general ward environments were clean and well-maintained, staff did not ensure that the clinic room and clinic equipment was kept clean and safe. We saw that clinic equipment, oxygen and the emergency bag were stacked in a corner of the clinic and the room was cluttered. Clinic room equipment including physical observation items, such as blood pressure monitors and thermometers were not routinely cleaned, and staff did not complete a record of cleaning. Staff did not document deep cleans of the clinic room and did not know whether there was a schedule for clinic cleaning. Staff were unable to describe the process for ensuring clinic equipment was cleaned between patients or routinely. During our second visit we observed that the clinic had been re-organised and items were stored safely and correctly.

Some staff were unaware of the location of the emergency grab bag and defibrillator and were unsure if this was stored in the clinic room. We raised this with the management team and a reminder was sent to all staff to confirm the location of these.

Nursing staff completed weekly clinic room audits, which included prescription checks and checks of fridge and room temperatures. Managers had not completed review forms at the end of each week and therefore no action had been taken to respond to the issues identified in the audits. This included missing fridge temperatures and incomplete audits.

The service complied with guidance on eliminating mixed-sex accommodation. The service admitted male and female patients onto different wards. The wards had single rooms and single sex lounges, and patients did not need to pass bedrooms of people of a different gender to access bathroom facilities.

Safe staffing

Managers had calculated the number and grade of nurses and healthcare support workers required. However, the number of staff calculated did not compliment the needs of all the patients and this meant that patients did not always receive safe, person centred care. On the female ward there were times where a shortage and gender mix of staff meant

that patients were unable to receive care in line with their individual care plan and did not receive appropriate interventions for their needs. For example, there was not always enough female staff on shift to provide appropriate observations for a patient requiring females to be present, as per her care plan. This meant there were occasions where two male staff members were present in her bedroom at night Since the date of our first visit, managers had reviewed staffing allocation on night shifts to ensure an appropriate gender mix of staff were available on duty.

The service had nursing vacancies and relied on bank and agency staff to ensure safer staffing numbers. However, patients, carers and staff told us that these staff were not familiar with patients' individual needs and were less able to manage risk. Following our inspection, the service has recruited seven healthcare workers, two staff nurses and a deputy ward manager to reduce the reliance on agency workers.

The service did not always have enough nursing staff, and staff could not observe patients in all parts of the wards. During our initial visit at night, we saw one ward with one staff member present with six patients. Another ward also had one staff member with five patients while observation levels for another patient utilised all other ward staff. The other wards each had two staff members. Staff told us that annual leave had an impact on the staffing level that evening and an agency worker did not turn up to work. Staff told us the night security staff (one person) covered for staff breaks across the wards when they were able to but could not cover all staff during a night shift.

There was not always access to a qualified nurse in communal areas in each of the wards. The day shift consisted of two qualified nurses responsible for two wards each, the night shift should have two nurses on duty. This was not apparent during our initial visit during the night shift. Two nurses were planned to be on duty, but this was not always the case, the night security book showed only one qualified nurse dedicated to all four wards of the hospital. However, staff told us this did not happen often, but recent staff absence had caused this shortage.

Staff shortages rarely impacted on leave for patients, staff told us members of the multi-disciplinary team (such as occupational therapy staff) covered shortages on the wards as well as staff breaks so patients were able to access leave, which we saw referenced in the July 2021 clinical governance meeting minutes.

Of the 18 staff who completed our staff survey, 11 staff disagreed or strongly disagreed that there was enough staff for them to do their job properly. At the time of the inspection there were nine vacancies at the service (two registered nurses and seven healthcare assistants). Since our inspection, the service has recruited seven healthcare workers, two staff nurses and a deputy ward manager.

The service altered the structure of the wards before the inspection was completed. The new system consisted of a ward manager with responsibility for two wards, assisted by a deputy ward manager, a designated senior nurse, designated healthcare workers and a night co-ordinator working on those wards.

Staff received mandatory training, permanent staff were 90.8% compliant overall. Compliance for immediate life support training (mandatory for registered staff only) impacted the overall completion percentage due to a low completion rate of 54.5%. Training in immediate life support had expired for five staff due to reduced course availability during the pandemic.

Assessing and managing risk to patients and staff

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff did not always assess and manage risks to patients and themselves well. Care records were not detailed and comprehensive with person centred information, some risk assessments were incomplete and lacked observation plans for patients requiring higher levels of supervision. For example, a patient had restrictions imposed inappropriately that did not promote recovery and known risks were not consistently managed.

Risk assessments had not always been fully completed. Risk assessments did not identify all risks referred to in progress notes and following incidents. This included risks to self, violence and aggression and risk of absconsion from the wards.

We found risk management plans to be generic and not specific of the individual needs of the patients. This meant that after incidents occurring where patient safety was a concern, plans to effectively manage any new risks were not always recorded or implemented. We found inconsistent approaches to risk without clear decision-making processes. Since our initial visit, we reviewed a further 14 care records that showed some improvements had been made to the records we had raised concerns with on the previous visit. However, some risk management plans were still generic or had out of date interventions.

Staff did not always identify and record any changes in risks to or posed by patients. During our review of care records, we saw a patients' risk alerts did not include violence and aggression, which had been highlighted within other information in their care records. Staff did not always have access to up-to-date clinical information which made it difficult for them to maintain high quality clinical records and effectively meet the needs of the people using the service. Since our initial visit, we reviewed documentation that showed improvement in clinical documentation and plans to address identified physical health concerns.

Use of restrictive interventions

We observed restrictive interventions such as limited access to personal items and outdoor space for one patient, that appeared disproportionate and unnecessary to manage the risks. [WJ4] Staff were unable to evidence the rationale for these restrictions and there was limited documentation of multidisciplinary discussion and decision-making.

The service did not have a seclusion room and no patients were secluded or in long term segregation. Ward staff had received training in restraint, and verbal de-escalation techniques were used by staff prior to the use of physical intervention. Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. During one use of rapid tranquilisation a staff member who was not trained in Prevention and Management of Violence and Aggression (PMVA) or trained in enhanced observation training undertook the enhanced observation duty which put the patients' safety at risk. This was not identified by staff as an incident, reported or escalated to senior leaders at the time of occurrence. When senior leaders became aware at a later date, they did not make a safeguarding to the local authority.

Safeguarding

Although staff received safeguarding training, we saw that there was a delay in referral of some safeguarding concerns to the local authority and relevant agencies due to internal review of the incidents by the team assistant social worker and hospital director.

Staff followed safe procedures for children visiting the ward. Patients could meet their relatives off the ward in meeting rooms, or in the community if they had leave.

Medicines Management

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff did not implement robust systems and processes to safely administer, record and store medicines. Staff did not always respond in a timely manner to external pharmacy audits. In the months prior to and during our inspection, there had been repeated medication errors, despite reported investigation and learning from previous errors. This included incorrect dosages being administered, and medication being administered without a prescriber's signature. We observed that staff had responded to an audit after 11 days, to say that a missing prescribing signature would be resolved. However, this signature was still missing on the day of our initial visit and the medication had been administered for the previous 15 days by different registered nurses. We observed that some issues identified on audits had not been responded to for up to 20 days. Some of the concerns raised included no, or incorrect, consent to treatment forms, and no monitoring forms for patients prescribed high doses of antipsychotics.

Further to this, we found that patients who were prescribed high dose antipsychotics did not always have a care plan in place and it was not always evident in multidisciplinary team meetings that the impact of the high dose had been reviewed. Medication is considered high dose when it exceeds the recommended British National Formulary doses.

We spoke to a visiting pharmacist who told us that there was an allocated member of staff who would normally respond to the audit. However, on the dates viewed during the inspection that member of staff had been on annual leave. The pharmacist did not have significant concerns regarding medicines management at the service.

Ward staff completed daily audits of prescription charts. However, the manager's weekly review had not been completed for the previous nine weeks. This led to repeated errors and no action being taken in response to identified shortfalls in practice. Staff had not always identified errors within prescription charts during the daily audits, such as missing signatures and incorrect consent to treatment forms.

We reviewed the care records of patients prescribed medications that required close monitoring and increased physical health checks. We found that staff had developed individualised care plans for these patients and monitored their physical health appropriately. Staff completed monthly side effect monitoring tools with patients.

Reporting incidents and learning from when things go wrong

Although most staff reported that they knew how to report errors, near misses or incidents, we saw evidence of safety incidents in progress notes not being reported as incidents, or no action being taken in response to some incidents. These incidents included insufficient staffing to manage patient risks, non-administration of emergency medication to manage patient risk, and no immediate action in response to identified safeguarding incidents. Staff not present during these incidents were unaware of these and managers had not taken action to investigate these and ensure lessons learned were identified and communicated to the team. Not reporting incidents in a timely manner increases the potential of patients and staff being exposed to risk for extended periods of time.

Internal safeguarding leads reviewed incidents reported and made the decision on relevant escalation and referrals to other agencies, such as the local authority safeguarding team. This process did not always identify incidents that needed to be referred to external agencies, as a result, local safeguarding teams were not always kept up to date with relevant incidents within the service.

While reviewing documentation during the inspection, we saw no evidence of lessons learned being shared across the service. Only seven out of 18 staff who completed the staff survey agreed that they received feedback about changes made in response to reported errors, near misses and incidents. Only seven staff also agreed that there was a strong emphasis on safety of staff within the organisation.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff were debriefed and received support after a serious incident. Staff told us they had received support from managers following a serious assault they sustained.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Good

Our rating of effective stayed the same. We rated it as good.

We did not inspect this key question at this time.

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

Good

Our rating of caring stayed the same. We rated it as good.

We did not inspect this key question at this time.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

We did not inspect this key question at this time.

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

Requires Improvement

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

Leadership

Leaders did not demonstrate the knowledge and experience to fully perform their roles. Recent changes in the management structure had left gaps in certain duties being performed and this had a knock-on effect within other areas of the service. The roles of leaders were not clearly defined and caused confusion as to roles, responsibility and accountability. Following our initial visit, the hospital director had held heads of department meetings to outline expectations of the multi-disciplinary team (MDT) in terms of their accountability and responsibility.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

At the time of our inspection, there was no registered manager in post. In the previous 12 months there had been two changes of staff for the hospital director role. The current hospital director had applied to become registered manager but was awaiting the outcome of this application.

During our inspection senior managers put in a plan to immediately allocate resources to the service to address the issues raised, strengthen the leadership capacity and address roles and responsibilities. Resources were also allocated to provide oversight of care records, risk management planning, and clinical governance processes.

Results from our staff survey showed that eight of the 18 respondents felt confident that actions were taken to address concerns raised with managers. Further to this 10 of the 18 staff disagreed that senior managers tried to involve staff in important decisions.

Vision and strategy

Not all staff knew and understood the provider's vision and values and how they (were) applied to the work of their team. Some staff told us that the service wasn't fit for purpose and didn't work to a rehabilitation model. Some staff told us that they felt admissions of patients were motivated by bed occupancy and referrals and admissions were not always appropriate due to the acuity of patients' mental health and increased risks.

Culture

Staff told us they did not always feel respected, supported and valued. Not all staff felt they could raise concerns without fear of retribution. We were told that staff had been reprimanded for previously raising a concern.

Staff did not receive regular supervision. This had been identified within a clinical governance meeting as an issue that contributed to staff feeling unsupported. A clear plan had not been identified to address this.

The service had planned future wellbeing days for the staff.

Governance

Our findings from the other key question demonstrated that governance processes were not operating effectively at team level and that performance and risk were not managed well.

At this inspection we found that there were gaps in processes, such as the managers review of the audit folder within the clinic room. With specific staff shortages such as a designated clinical lead and a lead nurse, there were shortfalls in following local policies and procedures. During our inspection, additional resources were allocated to address issues raised. The senior management team (SMT) lead for physical health from another site reviewed all physical health care plans. In addition to this, the regional governance manager dedicated two days a week for the service to undertake full reviews of care plans, risk management plans and the clinical governance process. The South West operations manager dedicated at least one day a week to support and help structure workload and re-establish the accountability in the heads of department

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

At this inspection we found that not all staff were clear about their roles in making safeguarding referrals, during our visit we saw evidence of a delay in referrals being made. Not all agency staff had access to the patient notes system, staff told us that some agency staff had to use paper notes until a person with access to the computer systems could upload the information at a later time. This could lead to misrepresentation of events and delays in important patient information being shared across the relevant staff teams.

There were systems and procedures in place to assign staff to the wards and to arrange for bank or agency staff that were not always effective. Inconsistencies in escalating shortages and shift cancellations at short notice were a regular occurrence. This meant that staffing levels were inconsistent and did not always compliment the needs of the patients on the ward.

Staff undertook multi-disciplinary team (MDT) meetings daily to discuss essential information. During our inspection, we observed an MDT meeting and saw that there were recovery focused conversations among staff that were present. Not all concerns discussed resulted in a plan, for example, this was evident with concerns around a patients' physical health.

Management of risk, issues and performance

During our visit we saw that management of risk was not always implemented appropriately. Agenda items under the heading 'Hot Topics' that were discussed monthly within the clinical governance minutes were apparent during our initial visit. The minutes dated March 2021 referred to staffing levels not reflecting the needs of the patients and patients with complex needs were only supported by one staff member covering the ward. Minutes also referred to the lack of "free responders for incidents" due to the allocated security staff member covering staff breaks or patient smoking breaks which would leave them unavailable. We saw this issue was still prevalent on our initial visit. Since our initial visit, the new staffing structure includes two night co-ordinators, each covering two wards as opposed to one previously covering all four wards. This provides more capacity for free responders to incidents as they occur.

Information management

The service used systems to collect data that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology they needed to do their work. The electronic record system was password protected and set up to help protect the confidentiality of patient records.

The hospital director had access to information to support them with their management role. This included information on the performance of their service against that of other services, such as the pharmacy quarterly reports overview which were displayed in the April 2021 clinical governance meeting minutes.

Learning, continuous improvement and innovation

Documentation we reviewed during our inspection evidenced that managers reflected on inspections of other services and considered how findings could be used to make improvements. However, an area identified for improvement related to poor gender mix of staff on male and female wards in June 2021 that would improve outcomes for patients on the female ward, had not been acted upon at the time of our initial visit. During our visit we informed the provider of a concern relating to gender mix on the female ward, further review of care records evidenced appropriate interventions implemented as a result.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did maintain accurate, complete and contemporaneous records of each patient or provide rationale to decisions made in relation to the care and treatment provided.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not always have enough suitably qualified, competent staff deployed to fully meet the needs of the people who use the service.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure medicines were prescribed and administered accurately, patients on high doses of medication did not have an associated care plan in place that were regularly reviewed.

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

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures	Managers did not ensure that restrictive interventions were monitored and proportionate to the patients identified risks.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure clinic equipment was cleaned and maintained, as well as an auditable record kept of this.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure an adequate ratio of staff had up-to-date training in immediate life support or aware of the location of the emergency equipment.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not ensure all incidents were investigated and lessons learned shared with all staff.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not identify, record and review risks of patients in a way that kept them safe.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Managers did not recognise, report and respond to patient safety incidents.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Medicines management audits were not reviewed in a timely manner, results escalated and appropriate action taken.