Garry and Jane Blake

Sherwood Lodge Independent Healthcare

Inspection report

29-31 Severn Road
Weston Super Mare
BS23 1DW
Tel: 01934631294
www.sherwoodlodge.co.uk

Date of inspection visit: 24 May and 1 June 2022
Date of publication: 28/09/2022

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Sherwood Lodge independent hospital provides community rehabilitation for adults with mental health disorders, some of whom may be detained under the Mental Health Act 1983.

During our inspection we raised a number of concerns with the provider and asked that they take action to make immediate improvements. For example, to the environment, equipment and the way risks were assessed for patients and how care was planned.

As a result of the significant concerns identified during the inspection, we wrote to the provider to seek immediate assurances about the safety of those using the service. We advised them that if there was not significant improvement in the safety of care, we would take enforcement action to ensure they address the issues. The provider submitted an action plan describing what it would do to improve and sent us some information to show what actions had been taken. Although we were assured that patients weren't at immediate risk of harm there is still much for the provider to do to ensure improvements continue and are embedded. We have also identified that the environment needs significant attention to ensure it can meet the needs of patients going forward. The environment is currently not fit for purpose.

As a result of our concerns we have rated the service as inadequate and placed it in special measures. We will continue to monitor the service closely.

Our rating of this service went down. We rated it as inadequate because:

- The environment and equipment were not well maintained. There was broken furniture and other damaged items throughout the premises. The clinic equipment was overdue calibration and a service. Staff had not completed comprehensive assessments of patient needs to ensure the suitability of the environment and allocation of upstairs bedrooms.
- The environment was not fit for purpose and it was difficult to see how staff, despite their best efforts, could provide contemporary community rehabilitative care in this environment. Many bedrooms were very small, some only a single bed length, with limited space to move around next to the bed and furniture. Bedrooms had partition walls in place to create single rooms. The partitions did not reach the ceiling to allow for natural light to enter the side of bedrooms without windows. However, this did not allow for the maintenance of privacy or dignity and patients without access to the windows could not control light or ventilation independently. There was limited room and facilities to support therapeutic activities. Outside space on site was limited to a courtyard that was generally used by those who smoked. There was limited green space and no separate space for those who did not smoke.
- The service did not always comply with same sex accommodation guidance. Staff were unclear on how same sex accommodation was maintained and the bathroom facilities did not allow for suitable gender separation.
- The service did not ensure that risk assessment and risk management processes kept people safe. Patients did not have contemporaneous and robust risk assessment and management plans. Most staff had limited involvement in the development of risk management plans and were not clear on the actions they should take to manage or reduce risk.
- Staff imposed some restrictions on patients without a clear rationale. This included limited access to bedrooms, which some patients did not have keys for and could only access with the support of staff. The service had also imposed financial charges on a patient for damages caused when they were experiencing challenges with their mental health or behaviour without clear rationale and an agreed plan of care in place.

Summary of findings

- Staff and managers did not always recognise and report potential patient abuse, and patient safety incidents. Managers did not fully investigate incidents to identify learning and ensure patients were safeguarded against the risk of abuse.
- Managers had not responded to a previous area for improvement highlighted during the last CQC inspection. Care records were difficult to navigate as documents were stored in different locations and files were over full. Staff did not have easy access to care records and were unable to locate the most up to date treatment and management plans. Daily handover records lacked detail and patient needs and risks were not clearly documented.
- The service was registered to provide rehabilitation and recovery to patients, including those detained under the Mental Health Act but the model of care was not clear. The provider stated that they used the Recovery Star model, but this was not clear in care plans. Consequently, patients who should be supported to move on to a less restrictive environment were not receiving the support necessary for their rehabilitation.
- Managers had not ensured that patients had easy access to multidisciplinary professionals including occupational therapists and clinical psychologists in line with a rehabilitation and recovery model of care.
- Most staff were not involved in the review of care and treatment plans and these were not updated regularly. Patients and carers were not always involved in the development or review of care plans and in care decisions.
- Working relationships with the GP surgery had broken down and managers tended to access out of hours service for physical health support rather than accessing support from their local surgery.
- Managers did not implement effective governance processes, that aligned with a rehabilitative model of care, to ensure that performance, quality and risk were managed well.

However:

- Families told us that staff supported, informed and involved them in their family member's care and patients said they were happy at Sherwood Lodge.
- Staff were generally committed to delivering kind and compassionate care, and it was clear that the majority genuinely cared about patients.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff felt supported by their peers and the leadership team.

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	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Sherwood Lodge Independent Healthcare

Sherwood Lodge independent hospital has been registered with the Care Quality Commission since 1 October 2010 to carry out the following regulated activities:

- Assessment of medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Accommodation for persons who require nursing or personal care.

Sherwood Lodge is an independent mental health hospital in Weston-Super-Mare, North Somerset, which provides community rehabilitative care and treatment of adults with mental health disorders, some of whom may be detained under the Mental Health Act 1983.

The service provides 24-hour residential care to both men and women and aims to provide a homely setting. The registration states the provider must only accommodate a maximum of 22 service users in receipt of the regulated activity of accommodation for persons requiring nursing or personal care, and those service users must be the only occupants of their rooms.

What people who use the service say

Most patients told us they were happy at Sherwood lodge and staff treated them with kindness. One patient told us they were unhappy with the size of their bedroom.

Families and carers told us that some patients had experienced successful admissions to Sherwood Lodge following numerous admissions to other settings, where their mental health had deteriorated.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the service. This comprehensive inspection was unannounced (the service did not know we were coming).

During the inspection visit, the inspection team:

- Spoke with the service manager
- Spoke with seven patients and two carers
- Spoke with eight staff members, including registered nurses, health care workers and the responsible clinician
- Looked at seven care records, and four medicines records
- Looked around the environment and clinic room
- Completed a short observational framework for inspection (SOFI)
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

Following the inspection, we raised concerns about the safety of the service with the provider. On receipt of an initial response to the concerns raised, CQC sent a letter of intent informing the provider of our consideration to use powers pursuant to the urgent procedure (for suspension, or imposition or variation or removal of conditions of registration) under Section 31 of the Health and Social Act 2008. The provider was offered an opportunity to present evidence to reassure us that the risks had been removed or were immediately being addressed.

The provider submitted an action plan setting out how they intended to immediately address the concerns raised and no urgent action was taken. However, we made it clear to the provider that there was still much to do and that the environment was not fit for purpose and needed significant attention.

Following receipt of the action plan we contacted the local authority safeguarding team, commissioners, NHSE and other system partners to discuss our concerns.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-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:

- Managers must ensure that the environment is fit for purpose and that patient's holistic care needs can be met. Managers must ensure that patient's privacy and dignity including gender separation is always maintained.
- Managers must ensure that the environment is well maintained, and timely action is taken to repair or replace broken or worn items.
- The service must ensure that all staff complete comprehensive, and individualised assessments of patient needs in relation to the environment and its risk. This must include up to date personal emergency evacuation plans.
- The service must ensure that staff recognise and report potential abuse and work with other relevant agencies to protect patients from abuse, and that all staff are appropriately trained in safeguarding.
- Managers must ensure any incidents are reported and notified to the CQC where appropriate, robustly investigated and any learning identified and shared with the whole team, and that learning is embedded into practice.
- Risk management plans must be up to date and must identify appropriate interventions in response to patient safety incidents, and to reduce the likelihood, or prevent, incidents reoccurring. Managers must ensure that staff know about any risks to patients and act to prevent or reduce risks.
- Managers must ensure that staff have completed and kept up to date with mandatory training and identify future dates for training that was unavailable during the coronavirus pandemic
- Managers must ensure that care records are kept up to date and easily accessible to all members of staff.
- The service must ensure that all patients have regular access to input from a multidisciplinary team, including occupational therapists and clinical psychologists.
- The service must regularly review, and update assessments of patient need and develop individual care plans to meet these individual needs.
- Managers and staff must ensure that verbal interactions with patients, and written care records are respectful, supportive and person centred at all times.

Summary of this inspection

- The service must ensure that robust systems are in place to assess, monitor and improve the quality and safety of the service provided. The manager must be clear on and deliver a service model in line with nationally recognised best practice. Governance processes must be aligned with, and reflective of the model of care provided.
- The service must ensure that the relevant notifications are submitted to external organisations, including the Care Quality Commission in a timely manner.

Action the service SHOULD take to improve:

- Staff should ensure clinic equipment is checked, maintained and cleaned regularly and that the relevant dates are documented.
- Staff should ensure they keep a record of clinic room deep cleans.

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	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

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

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

The environment had not been well maintained and it was unclear whether all areas had been robustly assessed to ensure they were safe and fit for purpose.

Staff did not always complete relevant assessments and management plans for patients with limited mobility or requiring support to mobilise, who were allocated to upstairs bedrooms.

Personal emergency evacuation procedure plans for some patients were incomplete and did not reflect the needs of the patients. For example, three patients were identified in their care records as requiring support with mobilising. However, their personal emergency evacuation plans identified that they should mobilise independently to the evacuation meeting point. Staff were unable to locate more recent plans within the care records. Following the inspection, the manager told us they had ensured all plans were up to date and available within the care records.

There were potential ligature anchor points throughout the environment. Managers had completed an environmental ligature audit tool, but this did not include reference to all potential ligature points and staff were unaware of the content and how to mitigate identified risks. Following the inspection, the environmental audit was updated to reflect risks and shared with staff. Staff told us that the service did not accept patients with specific suicidal risks. However we noted within care records that this had not always been the case, and there had been recent incidents of self-harming behaviours.

Staff were able to observe patients within all communal areas of the building. There was no means of observing patients without entering the patient's bedrooms to complete observation and engagement during the night.

The service did not always comply with same sex accommodation guidance. There were two upstairs corridors. On one side there were male and female patients allocated to individual bedrooms. There were a few steps between the male and female bedrooms. The bedrooms were not ensuite. There was an allocated toilet for females to share in one part of the corridor. However, the second toilet contained the only shower for the corridor. Staff were unable to clearly identify

whether the shower room was used by males or females. Some staff told us this was a shared bathroom. Other staff told us it was used as a toilet for males at night, and shower room for females in the day. Staff told us that males accessed a different shower room by going downstairs, through the communal areas, and upstairs to the corridor on the other side of the building.

The service provided a female only lounge.

There were nurse call systems and patients could access these in their bedroom.

Maintenance, cleanliness and infection control

The environment was not well maintained. There were broken items of furniture and some poor décor throughout the building. This included broken drawers, radiator covers, clocks, and bin lids. There were cigarette burns on the toilet windowsill, the flooring in bedrooms was in need of replacement, and the glass panel in the entrance door was taped following cracking eight days previously. One bedroom did not have any lights working. The manager showed us a maintenance log for the broken glass panel and light replacements, and these were due to be fixed. Following the inspection, the glass panel was replaced, and managers had started work to repair and replace flooring.

Staff made sure cleaning records were up-to-date and the majority of the premises were clean. Although, the clinic area had a dirty floor and did not appear to have been deep cleaned.

Staff followed infection control policy, including handwashing. Managers monitored staff implementation of infection prevention and control procedures.

Clinic room and equipment

The clinic room was within a thoroughfare between staff offices, and patient communal areas. Staff had access to relevant equipment but some equipment was overdue for service or calibration. This included the blood pressure monitor and scales. Staff did not keep a log of calibration and servicing of equipment and therefore were unclear on when newer items were due. Calibration confirmed whether equipment is recording accurate results. There is a risk of harm to patients if inaccurate results are recorded during physical health checks. The blood pressure monitor did not have a lid over the batteries and staff told us this was missing. The medicines disposal bin was open and not in a locked cupboard, making it accessible to any staff member. Following the inspection, managers purchased new clinic equipment to replace items that had not been serviced.

Staff did not keep a record of cleaning clinic observation equipment.

The service did not store resuscitation equipment although had access to emergency oxygen.

Safe staffing

The service had enough nursing and medical staff. However, staff were not up to date with all training that supported them to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had low vacancy rates. There were two night staff vacancies and these were being covered by agency staff familiar with the service.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The service manager could adjust staffing levels according to the needs of the patients.

Patients had regular one-to-one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled. However, staff told us that due to the mobility needs of patients and the number of patients at the service, they could only provide escorted leave for those patients once per week. Staff told us they would benefit from more staff to increase this.

Medical staff

The service had access to one consultant psychiatrist who was the responsible clinician for patients detained under the Mental Health Act and worked at a local NHS trust. The consultant psychiatrist reviewed patients a couple of times per month and was available at all times to attend the service in an emergency or contact as necessary.

All patients had access to a local GP. However, the GP surgery told us that the working relationship between them and managers at Sherwood Lodge had broken down and that the managers tended to access out of hours service for physical health support.

Mandatory training

The mandatory training programme met the needs of patients and staff. The service manager had completed a training needs analysis for the service. This included staff completion of a workbook with 17 courses including subjects such as safeguarding, infection prevention and control, first aid, manual handling, and mental health awareness.

However, all staff were overdue or had not yet completed training in non-abusive psychological and physical intervention (NAPPI). Only five out of 15 staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training. Four staff were due to complete this training in August 2022. There had been a delay in accessing the course during the coronavirus pandemic due to face to face courses being limited.

Assessing and managing risk to patients and staff

Managers did not ensure that risk assessment and risk management processes kept patients and staff safe. There were some restrictions in place for patients without a clear rationale.

Assessment of patient risk

Although comprehensive risk assessments were completed at the point of admission, staff did not ensure patients had up to date and robust risk assessments.

We found that risks identified within progress notes were not reflected within risk assessments. Staff did not have a good understanding of all potential risks to and from patients. Staff did not review risk assessments following any incident.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

All reviews of risk assessments had been completed by the manager and staff told us they were not involved in updating these. Six of the risk assessments we viewed had not been reviewed for at least 12 months. Following reviews of risk assessments staff did not make changes to these and some assessments had not been updated for up to seven years.

We asked staff whether there were more up to date risk assessments available and were told to speak with the manager, as staff did not have access to these.

Management of patient risk

Some staff told us they were not involved in the development of risk management plans and were not aware of these. However, staff told us that they discussed patient risk and management during handover. We viewed a range of handover records but found that these were written in shorthand and did not evidence risk discussions or management plans.

Patient risk management plans had not been reviewed during 2022. Although the manager had reviewed these prior to 2022, the reviews did not evidence consideration of the effectiveness of these and did not generally lead to any changes to the plans. Where patients had been involved in safety incidents, risk management plans had not been updated following these. Risk management plans were not robust and focused on interventions to respond to risk and identified limited interventions to reduce the likelihood of risk reoccurring.

We saw evidence in progress notes and on incident forms of incidents including, choking, falls, safeguarding concerns, aggression towards others, self-harm, absent without leave (AWOL), and sexual disinhibition. Staff had not identified actions taken to reduce the risk of reoccurrence and had not reviewed risk assessments and management plans following these.

We spoke with staff about specific patient risks around sexual safety and suicidal ideation, and staff were unsure of the management plans and interventions in place to manage these. Staff referred to the patient's recent track record and some patients' inability to easily mobilise as a rationale for not developing specific management plans.

Following the inspection, we raised these concerns with the service managers. Managers updated their handover sheet to include reference to risks and incidents.

Use of restrictive interventions

The service did not use physical restraint techniques and staff told us they used NAPPI and de-escalation when necessary. However, no staff were up to date with this training.

Staff did not prescribe or administer rapid tranquilisation and did not use seclusion.

There were some blanket restrictions in place, which included some patients not having keys to their bedrooms, and all smoking paraphernalia being stored by staff. Bedrooms were kept locked at all times but could be unlocked form the inside. Patients without keys were reliant on staff to access their bedrooms during the day. We discussed this with staff and were told that this was assessed on an individual basis but the assessment viewed did not evidence an individualised approach to these restrictions. The registered manager identified that a patient would be charged if they caused damage during times of challenge with their mental health or behaviour. However, this did not appear to have been part of an agreed plan of care.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safeguarding

Staff and managers did not take all necessary action to ensure patients were protected from the risk of abuse.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff had completed level two safeguarding training. Staff told us they were unaware of the level of safeguarding training they had received, and registered nurses including the manager, had not undertaken level three training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

However, we saw evidence of potential safeguarding incidents within the care records and staff had not reported these or worked with other agencies to review these and ensure patients were protected against risk of abuse. This included incidents of peer to peer physical aggression, and significant bruising of unknown origin on one patient noted on three occasions. This bruising had not been reported to the local GP surgery. Although staff had documented these within the care records, no further action appeared to have been taken and staff had not submitted safeguarding alerts or referrals to the local authority safeguarding team. Staff had not updated the patient's risk management plans and the incidents had not been fully investigated to consider safeguarding needs or necessary interventions to prevent future reoccurrences.

The service manager had not submitted safeguarding alerts to the local authority adult safeguarding team following safeguarding incidents and had not sent the relevant notifications to CQC. The service manager told us that safeguarding discussions had taken place internally and decisions made not to raise safeguarding alerts. We discussed this following the inspection and managers advised us that they would use the local authority safeguarding screening tool in future and discuss any queries with the local authority safeguarding team and CQC.

We discussed our concerns with the provider following the inspection. The provider reviewed their safeguarding policy in response to these, but we found that the updated policy contained reference to out of date legislation. This was amended by the provider after this error was highlighted.

The service had a children's visiting policy and staff followed clear procedures to keep children visiting the service safe.

Staff access to essential information

Staff did not have easy access to essential information and were unsure on the location of relevant assessments and documents within care records.

Patient notes were paper records and progress notes were kept in a separate folder and updated contemporaneously.

Care records were difficult to review, as the folders were over full, with some records torn or annotated rather than reprinted to reflect a change. All the care records we looked at contained out of date documents and staff were unable to locate up to date versions of assessments and management plans. The manager told us these were available elsewhere and had been inserted into records following the inspection.

The consultant psychiatrist had worked with the local NHS trusts to ensure access to patients electronic NHS records as needed.

Records were stored securely.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Medicines management

The service used systems and processes to safely prescribe, administer, and record medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff nurses monitored the effects of medications on patient's mental and physical health and discussed this with and the consultant psychiatrist as necessary. Contact with the GP surgery was largely limited to contacting the out of hours services.

Staff monitored the physical health and side effects for patients prescribed specific medicines such as lithium. Patients were supported to attend the necessary phlebotomy appointments at the local hospital.

The manager completed regular medicines and prescribing audits. An external pharmacist had previously completed yearly audits. However, this had not taken place since the start of the coronavirus pandemic, due to restrictions on visits to the service.

Staff did not develop medicines care plans but identified any specific needs or risks on a document at the front of the medicine administration record.

Staff completed medicines records accurately and kept them up to date.

We saw that a medicines disposal bin was accessible to any staff within the clinic area and had not been stored in a locked cupboard.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report incidents appropriately. Managers did not always investigate incidents and it was not clear what lessons were learned and how these were shared following incidents.

We identified 16 patient safety incidents during our review of patients' progress notes. Staff did not document actions taken to prevent future recurrences of these incidents or identify any learning. The registered manager told us that they monitored and investigated incidents at the end of each month and recorded the outcome on a tracker form. We viewed the last 12 months of incident trackers and found that 14 of the incidents we identified in progress notes had not been reported on the manager's incident tracker. This included incidents of patient falls, a patient choking, self-harm, physical and verbal aggression, patients exposing themselves, and a patient becoming absent without leave.

Where incidents had been included on the tracker managers had not completed a robust investigation of the incident or identified any learning to prevent future or occurrences or mitigate the future risk.

Following the inspection, we raised our concerns regarding the management of patient safety incidents and the manager took action to improve the incident reporting form, incident tracker, and staff handover documents.

Due to the limited documentation of incident investigations it was unclear whether staff implemented duty of candour and involved patients and families in any investigations.

Staff told us that they attended debriefs following incidents and discussed learning within handovers and team meetings.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers told us there had not been any serious incidents in the previous 12 months. However, staff informed us of an incident of a patient choking, which they referred to as 'serious' and required emergency first aid to resolve.

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

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission and developed individual care plans. Initial care plans were personalised, holistic and recovery-oriented.

However, staff did not regularly review care plans and these were not updated to reflect patients' assessed needs and changes in presentation.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. However, the care plans we saw in care records had not been reviewed for long periods of time, up to three years. Where care plans had been reviewed, these were all completed by the manager and staff told us they had limited involvement in the review and updates of care plans.

Some care plans were out of date and did not reflect the patients' needs. This included night care plans that referred to patients as completing independent personal care, despite having separate care plans that identified them as needing support with this. Staff had not completed relevant assessments and planned care in response to changes in patient's presentation and needs. This included needs in relation to incidents of falls or choking, and deterioration in physical or mental health.

Best practice in treatment and care

Staff provided a limited range of treatment and care for patients, this included support for self-care and the development of everyday living skills. However, patients did not have regular access to a range of professionals, such as occupational therapists and clinical psychologists etc., so therapeutic activities were limited to those that the nurses and support staff could provide.

Staff did not routinely utilise and update rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff supported patients with their physical health and encouraged them to live healthier lives.

Staff provided a limited range of care and treatment suitable for the patients in the service. This included supporting them with independent living skills, accessing volunteer opportunities, engaging in community activities and activities provided at the service. Staff supported patients to maintain relationships with their friends and families.

Managers told us that links and work with external resource centres and community organisations had been stopped during the coronavirus pandemic and had not yet restarted.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients had their physical health assessed soon after admission and regularly reviewed during their time at the service. Patients had access to GPs and community health services. Staff told us they supported patients to access and attend routine physical health reviews and specialist services as necessary. Staff monitored patients' physical health through regular routine physical observations. However, the GP surgery told us that the working relationship with the managers at Sherwood Lodge had broken down and therefore the managers tended to access out of hours service for physical health support.

Patients had access to specialist nursing services when required, such as tissue viability and district nursing.

All patients had care co-ordinators from the placing NHS trust who kept separate clinical and risk documentation. Care co-ordinators reviewed the patients as required. The registered manager told us that there was good working relationships between the care co-ordinators and the team at Sherwood Lodge.

The responsible clinician from a local NHS trust told us that staff provided effective care to support some very complex patients to work towards recovery in the least restrictive environment. The responsible clinician had good relationships with patients' care coordinators and communicated with them regularly.

Staff were not regularly utilising and updating recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. We saw evidence of staff previously completing recovery stars and assessment tools. However, these had been completed over 12 months ago and were not reviewed following a change in patient need.

Staff took part in clinical audits, such as medicines management and infection control. However, clinical records audits and pharmacist visits had stopped during the pandemic and staff had not yet restarted these.

Skilled staff to deliver care

The service did not have access to the full range of specialists required to meet the needs of patients.

Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not have regular access to a range of specialists to meet the needs of the patients. Sherwood Lodge employed registered mental health nurses and healthcare workers. If a patient required any other mental health speciality, such as occupational therapy or clinical psychology they could be referred to the local health services. However, the service did not regularly engage allied health professionals such as occupational therapists and clinical psychologists in the care of patients and therefore patients did not have access to a multidisciplinary team to support their care.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through annual appraisals and, constructive clinical supervision of their work. Staff told us they felt supported through regular clinical supervision and could access extra support as needed.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

During the coronavirus pandemic regular whole team meetings did not take place. However, staff utilised daily handovers to ensure they could communicate and provide necessary support to each other.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Multi-disciplinary and interagency team work

Managers did not engage openly and effectively with all external professionals to benefit patients.

Managers and staff told us they had good relationships and worked well with external teams to address patient needs. However, we spoke with local health and social care colleagues and found that they felt that relationships with the service were poor and that managers from Sherwood Lodge did not engage openly and regularly with external organisations.

Staff had effective working relationships with the visiting responsible clinician and patients' care coordinators. Care coordinators and the responsible clinician attended the service to complete reviews throughout the year and attended annual care programme approach meetings.

Staff told us they had regular meetings to discuss patient care, including daily handovers. However, we found that documentation of these discussions and decision-making in handover and within care records lacked sufficient detail to understand what had been communicated.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Although some staff were due training refreshers in the Mental Capacity Act, staff we spoke with had knowledge of the Act and its principles.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent and there was clear rationale for decisions where patients were assessed to lack capacity to consent.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards authorisation only when necessary and monitored the progress of these applications.

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

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with respect and dignity, and the environment did not ensure that patient's privacy and dignity was always maintained.

However, patients we spoke with told us that staff treated them with compassion and kindness, and it was clear that most staff genuinely cared about the patients.

During interviews we were given examples of staff not responding to patients appropriately. On our second visit we completed a short observation framework for inspection (SOFI2). These observations were used to capture the mood and engagement of patients and quality of staff interactions. We observed that staff did not always communicate with patients when they passed them in communal areas, or acted, such as turning off the television or playing music. Staff did not offer patients a choice or provide a reason for this action. We also observed a staff member directing a patient to 'lift your head' without addressing them first or initiating a positive interaction.

However, we also observed that staff engaged patients well in group activities, such as singing together and during 'pamper sessions'. We also observed staff to be supportive and compassionate when supporting patients with specific tasks on a one to one basis. Patients and carers told us that most staff were kind and supportive. The staff we spoke with were passionate about providing support and individualised care to patients with an aim of recovery and increasing independence.

Language used within the care records did not always appear respectful towards patients and indicated a punitive approach to patient incidents. This included staff referring to patients as 'demanding' and 'snappy' and did not identify whether there had been any supportive debrief with patients following incidents. Staff also referred to being 'firm', highlighting 'house rules' and 'consequences of behaviours', including financial payment to cover damages as an intervention to reduce reoccurrence of incidents.

The layout of bedrooms did not allow for privacy and dignity in all rooms. There were wall partitions which did not reach to the ceiling. Although, this enabled fresh air and natural light to enter all rooms, this prevented patients in these rooms from having private conversations or from controlling their access to fresh air and light/darkness. A downstairs bedroom window looked out on to an indoor communal seating area so patients and staff could see directly into the room. Staff had put a net up against the window, but this did not ensure the full privacy of the patient in this bedroom.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff could not demonstrate how they had regularly involved patients in their individual care planning and risk assessment.

However, staff actively sought patient's feedback on the quality of care provided more generally. **Staff ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff introduced patients to the ward and the service as part of their admission.

At admission staff involved patients and gave them access to their care planning and risk assessments. However, it was not always evident in care plans that staff had revisited patients' views since admission and involved them in updates to this.

Staff involved patients in care programme approach (CPA) meetings and care coordinators sought patient views during their visits to the service.

The service held monthly house meetings, which patients and staff attended. Staff kept minutes of the meetings and provided feedback to patients following these. Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services. Patients knew how to access advocacy and gave examples of support they were receiving from an independent advocate.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Families told us that staff supported, informed and involved them in their family member's care.

We saw evidence in care records of staff liaising with family and carers and seeking their views when planning care. Families and carers were invited to attend care reviews and supported to attend virtually if necessary.

Families and carers were encouraged and supported to visit the service (although this was restricted in line with national guidance during the pandemic).

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

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

Requires Improvement

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

Access and discharge

The model of care for the service was unclear. Managers were not clear on expected length of stay and therefore discharge was not managed in line with national best practice for rehabilitation services and some patients had stayed at the service for long periods of time.

There were 21 patients at the service at the time of our inspection. Of these, six patients were detained under the Mental Health Act. One patient was under a conditional discharge.

Managers reviewed patient's history and referral details and completed a face to face assessment prior to any admission. Patients had an opportunity to visit the site prior to admission.

The service is registered to provide the regulated activities, assessment and treatment for persons detained under the Mental Health Act 1983, and accommodation for persons who require nursing or personal care. Patients at the service had multiple and complex specialist care and treatment needs and it was not always expected that patients would be discharged from the service.

However, for patients receiving community rehabilitative care we would expect the length of stay to be between one to two years. Managers were not always clear on the model of care and type of rehabilitation being provided. The registered manager told us that they used the Recovery Star model but this was not always clear from care plans and staff were not able to articulate what this meant for patients. The service did not have an expected length of stay and therefore this was not monitored by managers to ensure patients did not stay longer than they needed to.

Staff did not start discharge planning at the point of admission, as would be expected within a rehabilitation service.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the environment did not support patients' treatment, privacy and dignity. Bedrooms were small with no en-suite, and there were limited areas for privacy.

The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. However, the bedrooms were small, many having been converted into single rooms from double rooms; some were only the length of a single bed. There was limited space to move around the bed and furniture and limited storage space in many rooms. In some bedrooms, furniture was placed in front of windows, reducing the access to ventilation and light. Some bedrooms were partitioned with a wall that did not reach the ceiling. In these bedrooms one side of the partition did not have windows, therefore the wall partitions did not reach the ceiling to enable natural light and fresh air to enter. Patients in the bedroom without a window could not control their access to light/darkness or ventilation. A fan was provided in some rooms. Patients were unable to access their bedrooms during the day, which staff told us was to promote recovery and sleep hygiene. Patients could unlock their bedrooms from the inside but generally staff held the keys to the bedrooms although we were told that some patients had their own keys. We noted that on a document identified as a bedroom risk assessment that 14 patients did not have a bedroom key. This indicated that they were either a smoker or non-smoker which seemed to be the only rationale for patients not having keys.

There was no means of observing patients without entering the patient's bedrooms to complete observation and engagement during the night.

There were two communal sitting rooms, a room with seats outside the clinic, and a dining room. There was also a female only lounge available. There was limited space within the building for patients to have private conversations. Patients had a secure place to store personal possessions.

On the upstairs corridors there were separate toilets for males and females. However, on the right-hand upstairs corridor there was only one shower room which was shared by male and female patients.

The service was registered to provide the regulated activity 'accommodation for persons requiring nursing or personal care'. However, there was limited space to provide nursing procedures or interventions due to small bedrooms and a small clinic area that was not accessible to patients.

There was a courtyard outside used as a smoking area. Managers had purchased gym equipment but a space to use this had not yet been completed. Outside space on site was limited to a courtyard that was generally used by those who smoked. There was limited green space and no separate space for those who did not smoke.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food.

There was flooring and furniture throughout the premises that was damaged and required replacement. Managers had started works to repair and replace flooring throughout the building.

Managers told us they had a five-year service development plan to improve the environment. However, this was in its early stages and had not yet been documented.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as art sessions, volunteering opportunities and maintaining family relationships.

The coronavirus pandemic had impacted on the number of activities that could be accessed within the community. However, staff encouraged patients to develop and maintain relationships both in the service and in the wider community. Staff supported patients to access and use library cards, bus passes and were in the process of identifying volunteering opportunities for one patient.

Staff supported patients on trips in the local area, including the beach and town centre. Patients had accessed individual art sessions and a hairdresser visited the site. The service previously had links with the local leisure centre and resource centre but these had not been utilised since the pandemic due to risk of infection. Carers and staff told us that patients who required an escort or support to go on trips to the local area went out once per week. Staff told us they would like this to be increased but were unable to do so because of limited availability of staff and a high number of patients requiring support.

Staff organised events and activities to celebrate events such as patient's birthdays, the New Year and the Queen's Jubilee.

Meeting the needs of all people who use the service

Staff helped patients with communication, advocacy and cultural and spiritual support.

The service was delivered from two Victorian semi detached houses which had been knocked through to create one building and therefore was not built for the purpose it was being used. There were steps throughout the ground floor of the building and a steep staircase on either side of the building leading to the bedroom floor level. Managers had installed handrails and ramps to support patients with limited mobility. However, staff did not document individual assessments of need in relation to the environment. There were patients in upstairs bedrooms with limited mobility and accessibility needs. There was limited space within bedrooms for any assistive equipment to be used.

Managers provided an example of effective multiagency working with the occupational therapy service to support a patient in returning to Sherwood Lodge after a stay in an acute hospital so ensuring necessary equipment was available.

Staff had access to interpreters and arranged for religious support if needed.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had access to information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

Staff understood the policy on complaints and knew how to handle them.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service clearly displayed information about how to raise a concern in patient areas. Patients, relatives and carers knew how to complain or raise concerns.

Patients we spoke with told us they knew how to make a complaint.

The service had received two complaints in the past 12 months. These had been received from members of the public and had been investigated and resolved by the manager. There were no themes identified.

If patients raised concerns, staff resolved these informally where appropriate and offered to investigate these formally,

The service used compliments to learn, celebrate success and improve the quality of care.

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

Inadequate

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

Leadership

Leaders believed they were delivering a good service and appeared genuinely to care for the patients. However, the model of care was not in line with expected, recognised best practice. Significant modernisation and updating of the service was required and leaders did not appear to fully recognise the extent of what needed to be done to ensure patients received up to date, safe and effective care and treatment.

Some external organisations told us that communication with the registered manager was not open or effective.

However, staff, patients and carers felt supported by managers and told us they were visible within the service.

Staff told us they enjoyed working at the service and were proud of their work and passionate about the care they provided. Staff felt able to raise concerns without fear or victimisation and felt confident to 'whistle blow' if necessary.

Carers, some external professionals, and patients praised the support and communication they received from the registered manager. However, some external professionals and organisations we spoke with told us they did not feel that communication with managers was always open and effective.

We found that staff referred us to the manager for a lot of our queries about care and told us they had limited involvement in the planning of care and running of the service. Staff were unable to locate the most up to date patient records, and management plans, and could not describe the policies and processes for investigating and learning from incidents, stating that the manager completed these tasks.

Vision and strategy

There was a lack of clarity on the model of the service and the rehabilitation provided to patients, including those detained under the Mental Health Act.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Managers had documented a vision for the service and staff could describe this. They told us this was achieved through promoting recovery and independence for patients.

Staff were passionate about their roles and having a positive impact on patients' lives and recovery.

However, both managers and staff were not clear on the model of the service. As a result, some patients remained at the service for long periods of time, and there was limited access to the range of specialists and therapies required to support the active rehabilitation to support patients to move forward in their recovery pathway.

Managers told us of a five-year service development plan for sustainability. However, this was in its infancy and had not yet been documented.

Culture

Staff felt respected, supported and valued and told us they could raise any concerns without fear.

However, feedback from some external professionals and organisation and our findings from the other key questions identified that the service was at risk of developing a closed culture.

Staff spoke positively about the ethos of the service, and the support and respect they received from their team and the manager.

We reviewed the service in line with CQC's closed culture guidance and were concerned there were risk factors for a closed culture to develop. We had concerns about the condition and suitability of the physical environment. We also had concerns about the lack of investigation of incidents and identification of learning, the internal decision-making; decisions about care and treatment for patients appeared to be made by managers, the lack of submission of notifications to external agencies, and the tone of language used in patients notes and some interactions. In addition, some external professionals and organisations told up that communications with the registered manager were not open or effective. These issues are potentially indicative of a closed culture and could put patients at risk of harm.

Governance

Our findings from the other key questions demonstrated that governance processes were not always operating effectively. Systems and processes to assess, monitor and make improvements where needed were not robust and risk were not always managed well.

Governance processes were not robust and did not ensure that incidents were recognised, investigated thoroughly, and lessons learned. Managers attended six monthly clinical governance meetings. The last meeting took place in October 2021. Incidents were identified as a standing agenda item within these meetings. However, the records of meetings did not include the content of discussions that took place. It was therefore unclear which incidents had been discussed and whether any learning had been identified in response to any investigations that had taken place.

The registered manager kept an incident tracker and reviewed these monthly. However, not all incidents within progress notes were detailed within the trackers and therefore it was unclear whether investigation had taken place. Managers did not ensure there was sufficient detail on the incident tracker to provide evidence of thorough investigation, action to be taken to prevent future risk, and lessons learned.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We reviewed the updated safeguarding policy for the service and found that this contained reference to legislation that was out of date.

Managers held a training log for staff but this did not detail the dates that training had been completed or rationale for staff not completing, or proposed dates for completion.

Staff referred the inspection team to the registered manager when asked about governance processes and some were unable to identify any learning for incidents or complaints.

The service did not routinely use recovery-based outcome measures and assessment tools and there was a lack of assessment and monitoring processes to review and identify how clinically effective the service was.

Management of risk, issues and performance

The identification and management of risk, issues and performance was not always sufficiently detailed to provide assurance of a safe and quality service.

Managers had completed environmental risk assessments and audits. However, staff were unsure about the processes to manage some identified risks, and not all issues had been identified within the ligature risk audit.

The service had a risk register in place which was reviewed annually, and matched risk issues identified by staff and managers.

Managers had not responded to the changing needs of patients, including deterioration of physical mental health, and reviewed this in line with the suitability and safety of the service and the environment. Assessments of the suitability of bedroom environments for individual patients had not been documented, and same sex accommodation guidance was not always adhered to.

Information management

Managers developed a quality assurance file and collected data of some incidents, complaints, and training. However, we found that the training log contained limited information on the dates and due dates for training courses, and incident trackers were incomplete with limited detail of investigation and learning.

Engagement

During the pandemic the service had not had any quality assurance visits by the commissioners. There was a planned review in the month following the inspection.

We were shown some positive feedback from commissioners and care coordinators on the care provided.

The GP surgery told us that communications with the registered manager had broken down and the local authority safeguarding team expressed concerns about the service not reporting safeguarding concerns appropriately and in a timely manner.

Learning, continuous improvement and innovation

Managers had celebrated staff successes with staff hero awards and medals.

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
Accommodation for persons who require nursing or personal care 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 Managers did not ensure that all incidents were reported and notified to the CQC where appropriate. All incidents were not robustly investigated, learning identified and shared with the team, or embedded into practice (Regulation 17(1), (2)). Robust systems were not in place to assess, monitor and improve the quality and safety of the service provided. There was no clear service model in line with nationally recognised best practice. (Regulation 17(1), (2)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patient's privacy and dignity was not always maintained. The service did not always comply with same sex accommodation guidance. (Regulation 10(1), (2(a))). Verbal interactions with patients, and language used within the care records did not always appear respectful towards patients and indicated a punitive approach to patient incidents (Regulation 10(1)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that risk assessment and risk management processes kept people safe. Patients did not

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	have contemporaneous and robust risk assessment and management plans. Most staff were not clear on the actions they should take to manage or reduce risk (Regulation 12(2)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not up to date with mandatory training. All staff were overdue or had not yet completed mandatory training in non-abusive psychological and physical intervention (NAPPI). Only five out of 15 staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training (Regulation 18(2)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff and managers did not always recognise and report potential patient abuse, and patient safety incidents. Managers did not fully investigate incidents to identify learning and ensure patients were safeguarded against the risk of abuse. Staff were not all appropriately trained in safeguarding (Regulation 13(1), (2), (3)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The environment was not fit for purpose. The environment and equipment were not well maintained. Staff had not completed comprehensive assessments of patient needs to ensure the suitability of the environment (Regulation 15(1)).

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The service did not submit the relevant notifications to external organisations, including the Care Quality Commission in a timely manner (Regulation 18, Registration).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Managers had not responded to a previous area for improvement highlighted during the last CQC inspection. Care records were difficult to navigate. Staff did not have easy access to care records and were not easily accessible to staff. (Regulation 9(3)). Patients did not have regular access to input from a multidisciplinary team, including occupational therapists and clinical psychologists (Regulation 9(1), (3)). The service did not regularly review, and update assessments of patient need and develop individual care plans to meet these individual needs (Regulation 9(1), (3)).