Thors Park

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Inadequate**
Are services well-led?	**Inadequate**

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

We rated Thors Park as inadequate because:

- Safety was not a priority. The provider did not have sufficient oversight to ensure the clinic room was maintained safely. Staff did not ensure the clinic room was organised, clean or tidy. Staff did not manage medications appropriately, dispose of expired medications and numerous miscellaneous items or replace equipment. The provider had not ensured the replacement of an oxygen cylinder despite being aware that it had remained empty since November 2018 or an ambu bag (a manual resuscitation bag) that had expired in 2011. The provider had not ensured the repair of the clinic room door. This compromised the security of the clinic room which led to a patient forcibly accessing the room during our inspection. As the clinic room door remained faulty and no temporary solution had been put in place, this remained a risk to patients and staff. The provider did not ensure the timely maintenance of the alarm systems. Staff were unable to know the location of a raised alarm without viewing the alarm panel in the nursing office as the panel in the ward area was inaccurate. Not all staff responded to the alarm when it was pulled. Staff reported personal alarms as faulty since August 2018. Although the provider had repaired and replaced staff personal alarms, staff continued to raise concerns that their alarms did not always work effectively. We were not assured of the provider's oversight and responsiveness to the safety of staff and patients. There were no effective system for identifying, capturing and managing issues and risks.
- Staff did not manage risks to people who use the services. Managers and staff missed opportunities to prevent or minimise harm. During the inspection, staff did not maintain enhanced observation levels for two patients as specified in their care plans and in line with the provider's observation policy. This issue had been identified in a recent focused inspection but the provider had not addressed our concern. We were therefore not assured that the provider had managed the risks posed by or to people using the service. Staff did not intervene in situations of challenging behaviour towards the inspection staff during the inspection. Managers were aware of staff's reluctance to intervene during incidents involving one patient and said they were providing training on this patient's positive behaviour support plans and provided training on how to maintain boundaries. Restraint records were not accurate. The provider had not ensured that staff were recording physical restraints used during incidents. We found three incidents where staff did not record the type of physical restraints used during an incident. Managers were unable to know the type and frequency of physical restraints used.
- The provider had not ensured they maintained parts of the environment adequately. Some parts of the

environment were dull and required re-painting. Two patients' bedrooms had damaged radiator covers that had not been repaired and one bedroom was very worn and damaged. The activity room was bare, required redecoration and was not conducive to therapeutic activities.

- The provider had not ensured that staff were up to date with all mandatory training including safeguarding children training which 74% of staff had completed and Mental Health Act training which 67% of staff had completed. The provider had not ensured their staff had met their target of 80%. Managers did not provide staff with regular supervision or appraisals. Data showed that 50% of staff received supervision and 21% of eligible staff received an appraisal in the twelve months prior to the inspection.
- The service did not always meet people's needs. Staff did not ensure they had records of care and treatment reviews. This meant they had limited records of actions required to support patients' discharge. When people complained about the service, the response was poor and the quality of investigations into complaints were poor. The provider did not always use their terms of reference for investigating. We reviewed four investigation reports, they lacked clarity about what was being investigated and investigators had not used all evidence available to form a judgement.
- Managers had no oversight of significant issues that threatened the delivery of safe and effective care. Issues were not always identified and adequate action to manage them was not always taken. Managers had not identified issues in the clinic room and staff continued to report personal alarms as faulty despite the provider repairing these. Staff continued to leave patients who required constant enhanced observations despite this being raised in a recent focused inspection. These issues compromised staff and patient safety.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	Thorrington ward is an eight-bed unit for men with learning disabilities, complex needs and/or challenging behaviours. Brightlingsea ward is a four bed unit for men needing more intensive support than is provided in Thorrington ward. There are two bespoke units for men who are unable to tolerate living in shared accommodation.

Summary of findings

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Thors Park

Services we looked at:
Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Thors Park

Oakview Estates Limited is the registered provider for Thors Park. The hospital is currently in the process of integrating with Cygnet Healthcare. Thors Park is an independent hospital that provides support for up to 14 men. At the time of the inspection, there were 11 men receiving care and treatment at the hospital. Based in Thorrington, North East Essex, Thors Park provides support and treatment for men with learning disabilities and complex needs. The provider accepts patients who have additional mental and physical health needs, and those who have been detained under the Mental Health Act. The service comprises three elements:

• Thorrington Ward is an eight bed service that provides assessment and intervention for men with learning disabilities, complex needs and behaviours.

• Brightlingsea ward is a four bed service for individuals who require support that is more intensive. There are four self-contained, bespoke apartments.

• There are also has two bespoke single person apartments that provide a more independent living environment.

Thors Park is registered with CQC to carry out the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury.

The provider did not have a registered manager. The manager was awaiting their fit and proper persons interview at the time of the CQC inspection. The provider had a controlled drugs accountable officer.

Thors Park has been registered with CQC since 28 November 2012. Since registration, there have been seven inspections completed by CQC. The report of the last comprehensive inspection was published in March 2018; at which time the overall rating was good. The last inspection was a focused inspection on the 11 October 2018 and 01 November 2018. We did not change the rating of the provider during this focused inspection because we did not cover all aspects of each domain.

During the last inspection, the following breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified:

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The provider had not ensured that systems were in place to ensure that they could deploy sufficient staff with suitable skills and knowledge.
- The provider had not ensured that they completed observations in accordance with care plans and the provider's policy.
- The provider had not ensured that staff had a rest break.
- The provider had not ensured that staff were reading and following patient's positive behaviour support plans or their care plans.
- The provider did not respond to complaints in a timely manner.
- The provider did not ensure staff used physical restraints in line with their training.
- The provider had not investigated incidents in accordance with their own policy.
- The provider had not ensured staff could identify poor care and treatment or raise concerns.
- The provider had not ensured staff were completing physical health monitoring.

Following this inspection, there remained issues identified at the last inspection. More details can be found in the report.

Our inspection team

Summary of this inspection

The team that inspected the service comprised of two CQC inspection managers, two CQC inspectors, one specialist advisor and one expert by experience. An expert by experience is a person with knowledge of using services, or caring for someone who uses services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- spoke with thirteen staff including doctors, nurses, support workers, activity co-ordinators and psychologists
- spoke with two patients
- spoke with two relatives of patients
- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the registered manager
- looked at eleven care and treatment records of patients
- carried out a specific check of the medication management and the clinic room
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Two patients we spoke with gave positive feedback about the care they had received. For example, one patient said they enjoyed the activities they were able to participate in particularly the support they had received with improving their cooking skills. Another patient was due to leave the hospital and gave positive feedback about the majority of staff although they did say the high levels of staffing required did mean they were not always familiar with the staff working at the hospital. The patient spoke positively about the support they received with a complaint they had made and their discharge.

Feedback from the provider's family survey showed themes relating to improving communication with families and patients. One family member asked for improved activities in the community and another relative raised concerns about the safety on the wards, particularly about the level of confrontations between patients. One relative gave positive feedback and said the care and treatment their family member had received was very good.

Managers had sought feedback from patients using a pictorial and an observation questionnaire covering a range of areas including: people, care and treatment, environment, activities and coming to the hospital. Results from the pictorial questionnaire showed that patients generally responded positively to questions

Summary of this inspection

asked. The majority of patients reported they were more than 80% 'happy' with all areas except for the activities which they were 63% happy with. Patients using the observation questionnaire again responded positively stating they were above 80% satisfied with all areas except activities which they were 32% satisfied with.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- Safety was not a priority. The clinic room was disorganised, dirty and untidy. The provider had not identified issues or maintained the clinic room safely. Staff did not maintain equipment or manage medication adequately. Staff did not replace expired or empty equipment including the oxygen cylinder which was empty since November 2018 and the ambu bag, a bag used for manual resuscitation which had expired in 2011. Staff did not dispose of expired medications, creams, liquids, equipment, three sharps' bins and numerous boxes of miscellaneous items. The provider had not ensured the repair of the clinic room door. This compromised the security of the clinic room which led to a patient accessing the room during our inspection. As the clinic room door remained faulty and no temporary solution had been put in place, this remained a risk to patients and staff.
- The provider did not maintain the alarm system properly or ensure that staff responded when an alarm was raised. This put both patients and staff at risk. The alarm panel in the ward area was faulty. This meant that staff had to go into the nursing office to determine the location of a raised alarm. Not all staff responded to an alarm when it was set off by CQC staff. The provider had repaired and replaced staff personal alarms but staff continued to raise concerns that their alarms did not always work effectively. Staff minutes showed that staff reported these as faulty from August 2018 until January 2019.
- The provider had not maintained all areas of the ward environment adequately. Some parts of the ward were dull and required re-painting. Two patients' bedrooms had damaged radiator covers that had not been repaired and one bedroom was very worn and damaged. The activity room was bare, required redecoration and was not conducive to therapeutic activities.
- Staff did not manage risks to people who used the services. Staff and managers missed opportunities to prevent or minimise harm. Staff did not maintain enhanced observation levels for two patients during our inspection, as required by the care plan due to risk. We observed staff leaving patients alone for short periods of time; whose risk assessment had

Summary of this inspection

determined required two staff members to be with them at all times. This was despite the provider recently increasing staff establishment levels to address this issue and CQC having raised concern about observation practice previously.
- The provider had not ensured that staff were up to date with all mandatory training including safeguarding children training which 74% of staff had completed and mental health act training which 67% of staff had completed. The provider had not ensured their staff had met their target of 80%.
- The provider had not ensured that staff were recording physical restraint appropriately. We found three incidents where staff did not record the type of physical restraints used during an incident. This meant the provider was unable to know the frequency and type of physical restraint used with patients.

However:

- The provider block booked and used regular agency staff to ensure safe staffing levels and consistency for patients.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Systems to manage patient care were confusing. Each patient had six care files that contained information about their care and treatment. Access to current information was difficult.
- Managers did not provide staff with regular supervision or appraisals. Data showed that 50% of staff received supervision and 21% of eligible staff received an appraisal in the twelve months prior to the inspection.
- The provider had recently secured a service level agreement with a local GP and was registering patients with this service.

However:

- Staff received training in positive behaviour support. Staff attended a patient specific training programme that was provided monthly by psychologists.
- Patients had access to psychological therapies. Psychology staff completed comprehensive positive behaviour support plans for patients and analysed incidents to gain themes and trends of behaviours for each patient.

Are services caring?

Good

We rated caring as **good** because:

- Some staff showed passion for their work with patients and gave detailed examples of how they worked with complex patients and their understanding of patients' needs.

Summary of this inspection

- Staff used communication cards to be able to communicate more easily with patients. We observed staff using these during the inspection.
- The provider used easy read leaflets with patients to review their rights and develop care plans.
- Patients had 'my care plans' completed which demonstrated involvement with patients in care plan formation.
- Patients were supported to complete feedback surveys by using adapted pictorial and observation questionnaires for patients with a learning disability. The provider took action following the feedback from the survey.

However:

- While the provider held monthly patient forum meetings on the wards, the minutes were very brief and did not provide feedback on actions from previous meetings.
- The provider sought feedback from family members by sending out questionnaires to all relatives and received five responses. However, the provider did not take action following receipt of feedback from relatives.

Are services responsive?

Inadequate

We rated responsive as **inadequate** because:

- The quality of investigations into complaints was poor. We reviewed four investigation reports and found that two had been completed inadequately. One report did not make sense and related to two separate incidents. The provider had not used all available evidence to form a conclusion about the second investigation which related to unexplained injuries to a patient.
- The patients at Thors Park had long lengths of stay. This is not in line with the ambition of the transforming care programme. The provider did not ensure they had minutes of care and treatment reviews which meant it was not clear whether they addressed the required actions to support patients towards discharge. However, other evidence suggested that the provider had made reasonable attempts to do this.

However:

- Patients received interventions as detailed in their care plans, for example staff supported patients to learn skills in the occupational therapy kitchen to prepare for discharge.

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

Summary of this inspection

- Managers had no oversight of significant issues
- Managers had not taken adequate action to repair personal alarms and the alarm system in a timely manner. Staff had raised concerns about faulty alarms since August 2018. Although the provider had repaired and replaced staff personal alarms, staff continued to raise concerns that their alarms did not always work effectively.
- Managers did not ensure staff completed patient enhanced observations in line with patient care plans and the provider's observation policy. The provider had received a previous requirement notice for this. Managers had not taken adequate action to ensure this was not repeated.
- Managers had not ensured all staff were fully supported for their roles. Managers had not ensured that all staff were in receipt of regular supervision and appraisal or that staff had completed all mandatory training within the provider's target of 80%. The provider had previously received a requirement notice for poor supervision and appraisals in December 2016. Managers could not be sure staff were adequately supported or skilled to conduct their role.
- Managers did not ensure that staff recorded all physical restraints used during incidents.

However:

- The provider encouraged and supported staff with raising concerns. Staff had recently raised several concerns and were supported by managers to do so.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

At the time of the inspection, ten patients were receiving care and treatment under the Mental Health Act.

Sixty seven per cent of staff had received training in the Mental Health Act and the Mental

Health Act Code of Practice.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

The Mental Health Act manager completed audits on the application of the Mental Health Act and Code of Practice.

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

Patients had easy access to information about independent mental health advocacy and staff supported patients who lacked capacity by referring to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand using easy read information, repeated as necessary in accordance with the Mental Health Act Code of Practice and recorded it clearly in the patient's notes each time.

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

Staff stored copies of patient's detention papers and associated records correctly and staff could access them when they needed to.

Staff completed detention paperwork correctly and kept copies in patient notes for staff reference.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of inspection, one patient was receiving care and treatment under deprivation of liberty safeguard authorisations (DoLS).

Eighty nine per cent of staff had received training in the Mental Capacity Act.

The provider ensured independent mental capacity advocates were available to support patients who lacked capacity. Independent mental capacity advocates are a legal safeguard for people who lack the capacity to make specific important decisions.

Registered staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could refer to the provider's The Mental Capacity Act policy, which included Deprivation of liberty safeguards if needed.

Staff assessed patients' capacity where appropriate and we saw evidence of this in the notes. Staff had completed Mental Capacity Assessments appropriately, with evidence given for the judgements reached.

Staff supported patients to make decisions. The speech and language therapist supported patients with their communication difficulties when needed.

Where patients lacked capacity, best interest decision meetings took place for significant decisions.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Inadequate
Well-led	Inadequate

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Safety was not a priority. The provider had not identified issues or maintained the clinic room safely. The clinic room was disorganised, dirty and untidy. The clinic room sink was stained, the examination couch was ripped, and the skirting boards were dirty.

Staff had not replaced the oxygen cylinder which was empty since November 2018. Three out of four medications were expired in the fridge including two boxes of Lorazepam ampoules which had expired in July 2018 and August 2018, and a box of flu vaccine ampoules had expired in June 2018. A bag valve mask, a bag used as a manual resuscitator, had expired in 2011.

There was a lack of organisation in the clinic room. Staff had not labelled the shelves or drawers and shelves were disorganised and messy. Staff had not disposed of expired equipment such as cannulas which expired in February 2017, lancets which had expired November 2018 and swabs which had expired August 2016.

We found many miscellaneous items including a set of demo teeth, out of date dressings, sterile water, bowls, old alarms, batteries, dirty and worn tablet crushers with remnants of old tablets engrained within them. Staff had not disposed of three full boxes of sharp bins, one box full of out of date syringes and one box full of out of date liquids and creams. The provider's own clinic room audit in the provider information submitted to us prior to the inspection, showed similar issues which had not been addressed.

Staff did have access to resuscitation equipment and emergency drugs.

The provider's alarm system was faulty. The alarm panels displaying the location of an activated alarm did not work on the ward areas. Staff had to attend the nursing office alarm panel to find out where an alarm had been activated on the ward. We pulled the alarm whilst on site and it took 24.04 seconds for staff to respond to the alarm. Some staff either walked past when the alarm was sounded or did not respond to the alarm at all. This included managers. We were not assured of the safety of staff and patients.

Staff were not able to observe all parts of the wards due to blind spots. The provider used closed circuit television, but it was not routinely monitored by staff to observe patients. However, staff nursed patients on continuous observations to mitigate any identified risks.

Managers identified and mitigated against ligature risks on the wards. A ligature anchor point is anything that could be used to attach a cord, rope or other material for the purpose of strangulation. Staff mitigated against any ligature risks by using individual patient risk assessments which included enhanced patient observations.

The ward complied with the Department of Health guidance on eliminating mixed sex accommodation. The ward was single sex with en suite facilities within each bedroom.

The provider did not have any seclusion rooms. Seclusion is the supervised confinement of a patient in a room, which

may be locked. Its sole aim is to contain severely disturbed behaviour likely to cause harm to others. Managers reported no patients were secluded between 02 November 2017 and 02 November 2018.

Staff completed daily cleaning records which were up to date and demonstrated regular cleaning of the ward areas. The clinic room did not feature on the cleaning records. Some parts of the environment were dull, required re-painting and were damaged. We observed two bedroom radiator covers broken, some parts of the wards were dark, some areas required re-painting and were tired looking and worn. One patient bedroom was very worn, basic, parts of the wall were damaged and the bathroom had a closed sign saying "Hazard, keep shut at all times". The activity room was bare, dirty, required re-painting, had paint splashed on the floors, had a broken table tennis table and was not conducive to therapeutic activities.

Staff completed environmental audits, which highlighted areas of concern within the hospital. The provider employed two maintenance operatives. Staff used an onsite reporting system to log when repair requests and other maintenance issues. The clinic room door was faulty and not secure. Staff struggled to close the door which would not align correctly and as a result a patient presenting aggressively, was able to gain entry to the clinic room twice during our inspection. Managers told us the door had been repaired three times previously and remained faulty. The provider had sourced and replaced the clinic room door on 31 January 2019. However, the provider had referred back to the contractor due to poor workmanship and was awaiting an outcome for repairs or replacement. As the clinic room door remained faulty and no temporary solution had been put in place, this remained a risk to patients and staff.

We observed hand washing guidance displayed throughout the wards next to hand basins for staff and patient use.

CCTV timings were not accurate. Managers had told us they used CCTV to investigate incidents. However, the CCTV timing was inaccurate by one hour which meant that the CCTV was not an accurate method to use for investigations. The provider told us they were waiting for this to be repaired.

Safe staffing

Data provided between 01 July 2017 and 01 November 2018 showed the nursing establishment as five, with no vacancies. For support workers the establishment was 48. There were 30 vacancies. At the time of the inspection vacancies reduced to 27. Managers reported on occasions the wards worked with less staff than required but that managers supported staff with this shortfall by working on the ward. The provider reported a current vacancy rate for all substantive staff of 17%.

The service used bank and agency staff to cover sickness, absence, vacancies and continuous observations. Between 01 July 2017 and 01 November 2018, 667 shifts were filled by bank and 913 shifts were filled by agency staff.

The provider supplied data that showed a staff sickness rate of 8.3% between 01 July 2017 and 01 November 2018. Data provided between 01 July 2017 and 01 November 2018 showed that 24 staff had left the service.

The provider had a rolling recruitment programme. Managers had recruited three new support workers who were currently completing their induction and shadowing staff in the service.

Following a recent focused inspection where the provider had insufficient staff to complete patient enhanced observations, managers used the staffing ladder tool to ensure that the staffing establishment met the needs of the patients. Managers had increased the staffing establishment per shift from 22 to 24. This included two 'floating' staff to support teams with observations, breaks and responding to incidents. However, during our inspection we observed staff leaving patients who required enhanced observations. In one example, a patient was left with just one staff member. This patient required two staff at all times. In another example both staff left a patient for a short period of time. This patient also required two staff at all times.

Where vacancies existed, the provider used regular bank and agency staff to ensure safe staffing levels on the wards. Where possible, the provider block booked agency staff to ensure continuity of care for patients. The provider ensured all agency staff undertook a service induction to familiarise them with the patients and the running of the service. New staff had a buddy to support them with the induction process.

Inadequate

Wards for people with learning disabilities or autism

The provider deployed sufficient staff to ensure patients had time with their named nurse. Activities were rarely cancelled due to staffing levels.

The provider deployed sufficient staff to safely carry out physical restraints.

The provider had an on-call consultant rota to ensure a doctor could attend the ward in an emergency. Staff called the emergency services for medical emergencies.

Staff were not up to date with mandatory training. The provider used a training matrix to record and track compliance with training. Training topics which did not meet the providers target of 80% included: safeguarding children (74%), medication management (70%), food safety (72%), fire warden (33%) Mental Health Act (67%) care certificate (59%), legionella (67%) and epilepsy training (71%).

Assessing and managing risk to patients and staff

The provider reported no incidents of seclusion or long-term segregation of patients between 02 November 2017 and 02 November 2018.

The provider reported 42 incidents of restraint between 02 November 2017 and 02 November 2018. Managers were unable to provide information on how many different patients had experienced restraint. No incidents involved staff placing patients in the prone position (prone restraint occurs when a patient is positioned chest down and is physically prevented from moving out of this position). Staff told us they used restraint techniques as a last resort. Over the same period, the provider reported no incidents of restraint resulting in the administration of rapid tranquilisation. The National Institute of Health and Care Excellence defines rapid traquilisation as the 'use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed'.

Staff received training in physical restraints (restraint). At the time of the inspection, 97% of eligible staff had completed physical restraint training and all staff had completed their breakaway training.

We reviewed eleven care and treatment records. Staff completed risk assessments on admission and reviewed them regularly during care review meetings or as required following an incident or change in risk.

We did not observe any blanket restrictions at the hospital. The term 'blanket restrictions' refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application.

The provider had a policy for safe and supportive observations. Staff used different levels of observations dependent on the level of risk. Staff reviewed observation levels regularly and during multi-disciplinary team meetings. However, as mentioned above, we observed occasions where staff did not follow the policy.

The provider had a policy for searching patients. Staff searched patients upon return from leave if they were at risk of bringing contraband into the hospital.

Staff did not receive all safeguarding training in line with the provider's target of 80%. Ninety two percent of staff completed safeguarding adults training and seventy four percent of staff received safeguarding children training.

Staff we spoke to knew how to make a safeguarding alert and described what would be a safeguarding concern.

From 31 December 2017 to 31 December 2018, staff reported 17 safeguarding concerns to the local authority for investigation.

Staff did not fully adhere to medicines management procedures. Records demonstrated that staff were completing regular checks of the clinic room to ensure medication was stored and managed in line with Nursing and Midwifery Council (NMC) guidelines. However, expired medications remained in the clinic room fridge and a box of expired liquids and creams remained in the room without disposal. This was raised with the manager who said their agreement with pharmacy does not include disposal of medications and that clinical waste was collected every 3-6 weeks from the hospital. We were not assured that this was the case due to the timeframe of the expiry dates of the medications and the volume of creams and liquids that had accumulated. The controlled drug (CD) key was not separated from the main bunch of medication keys in line with best practice. Staff were initially unable to find the CD key despite it being kept on the main bunch.

Inadequate

Wards for people with learning disabilities or autism

We reviewed all patient medication prescription charts, which showed staff recorded the dispensing of medication appropriately. Medication was stored in a locked cupboard with a separate cupboard for controlled drugs. No controlled drugs were in use at the time of our inspection.

The provider had a room for family and child visits to take place separate from the ward areas.

Track record on safety

The provider reported five serious incidents from November 2017 to November 2018. All serious incidents related to unexplained injuries of patients. Of the four recent serious incident reports reviewed during the inspection, three serious incidents related to incidents of abuse by staff towards patients.

The provider had a current organisational safeguarding investigation ongoing by the local safeguarding team due to allegations of abuse by staff towards patients. This resulted in a focused inspection by CQC. The provider is in the process of working on their action plan as a result of the recent focused inspection.

Reporting incidents and learning from when things go wrong

Not all staff reported physical restraints on the incident reporting system. The provider had a process in place for staff to record incidents which involved healthcare workers completing handwritten incident forms and giving this information to qualified nurses. They assessed whether the incident required reporting on the system. A clinical psychologist completed a 'functional behavioural analysis' review to look at all incidents for patients in the past month and produced a report for the multi- disciplinary team to review. This information was to enable staff to understand patient behaviours. To complete this review, the clinical psychologist relied on information being reported on incident forms by staff. We looked at this review for ten patients which covered the timeframe between 14 November 2018 and 05 February 2019. We found three incidents where staff did not record the type of physical restraints used during an incident. This meant the provider was unable to know the frequency and type of physical restraints used with patients.

Staff generally received lessons learnt information in team meetings both internal and external to the service. However, we reviewed team meeting minutes from August 2018 and found that lessons learnt were not included in the standard agenda.

Managers had not adequately actioned staff feedback for repair or replacement of alarms at staff meetings. We reviewed meeting minutes from August 2018 to January 2019 and found that staff had raised concerns with alarms not working at the service and requiring repair. Despite the provider repairing and replacing staff personal alarms, staff continued to raise concerns that their alarms did not always work effectively. Staff meeting minutes in January 2019 showed that staff were still raising concerns about alarms not working effectively.

Managers did not record minutes of staff debriefs after incidents.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We examined eleven care records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

The clinical psychologist completed positive behaviour support plans for patients, with input from the multi-disciplinary team. These plans were of good quality. They contained several proactive and reactive strategies to a variety of known triggers and early warning signs in relation to patients' behaviour and presentation. Brief copies of these plans were kept on hand in patient bedrooms with clear guidance on how staff could support patients. However, as mentioned above, we found evidence that staff were not always recording the frequency and type of physical restraint used.

Inadequate

Wards for people with learning disabilities or autism

Staff completed holistic and recovery focused care plans. These covered a range of needs including personal care needs, diet and nutrition and activities. Staff reviewed care plans regularly during patients care review meetings. Staff offered patients a copy of their care plan and recorded when patients had been unable or unwilling to sign their plans. However, one patient did not have an epilepsy care plan despite this being a known risk for this patient who was on epileptic medication and had seizures. This was previously recommended in October 2018.

Records for patients were vast. Patients had six care files each which made accessibility of information difficult. The provider had duplicated information within these files and it was time consuming to find documents. Staff raised similar concerns, but no action had been made to remedy this.

Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence guidelines when prescribing medication. Staff told us they followed National Institute for Health and Care Excellence guidance on the use of antipsychotic medication. We reviewed the patients' prescription charts and saw that medical staff prescribed anti-psychotic medication in line with NICE guidance. Doctors had implemented the initiative 'stopping the over medication of people with a learning disability' (STOMP) to monitor the use of medication for patients.

Patients had access to psychological therapies. Clinical psychology staff completed comprehensive positive behaviour support plans for patients and analysed incidents to gain themes and trends of behaviours for each patient. Clinical psychologists provided monthly patient specific training to staff where a patient was presented and discussed.

Patients had access to physical health care. The provider had recently registered their patients with a local GP practice and patients accessed physical healthcare from the hospital consultant, and attended the local acute hospital walk in centre if required. Staff monitored the physical health of patients in the multi-disciplinary meetings. Staff accessed physical healthcare specialists for patients via referral from the hospital consultant. Patients had health action plans. The provider had recently arranged a service level agreement with the local GP service to enable patients to register with a GP.

Staff used recognised rating scales such as health of the nation outcome scales (HoNOS), outcomes star and LUNSERS (The Liverpool University Neuroleptic Side Effect Rating Scale), LUNSERS is self-rating scale for measuring the side-effect of antipsychotic medications.

Staff completed these with patients.

The provider offered a preceptorship programme to all newly registered nurses to enable them to consolidate their learning into practice and confidently take on the role and responsibilities of a registered nurse.

The provider employed a nurse consultant who took the lead on providing specialist training for staff including epilepsy and learning disability training.

Staff completed audits on the use of anti-psychotics and physical healthcare.

Skilled staff to deliver care

The team consisted of a consultant psychiatrist, nurses, an occupational therapist, support workers, speech and language therapist, activity co-ordinator and a consultant clinical psychologist. The local authority provided social work support.

All staff completed an induction prior to commencing work on the wards. This included safeguarding, health and safety, information and data governance, conflict resolution and physical restraint techniques. The provider told us all bank and block booked agency staff completed the provider's induction programme prior to working with patients. Managers allocated a buddy to support new staff for the first two weeks of working within the service.

Staff received training in positive behaviour support. Staff attended a patient specific training programme that was provided on a monthly basis.

The provider required all eligible support workers to complete the care certificate within three months of employment. The care certificate was officially launched in March 2015. It aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care. At the time of the inspection, 61% of eligible staff had completed this training.

Inadequate

Wards for people with learning disabilities or autism

Managers did not provide staff with regular supervision. Data from 01 November 2017 to 01 November 2018 showed that 50% of staff received supervision. This did not meet the providers target of 80%.

Managers did not provide staff with regular appraisals. Data at the time of the inspection showed that 21% of 49 eligible staff received an appraisal in the 12 months prior to the date of our inspection.

Managers carried out investigations into poor staff practice and, where necessary, put support plans in place to improve the practice of staff members. Human resources supported managers to do this. Data provided showed five staff members had been suspended from the service on disciplinary grounds since September 2018. These were support workers.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and documented plans in patient notes. A separate 'MDT' file for individual patients contained the multi-disciplinary review notes.

Ward teams had working relationships with external teams and organisations including other healthcare providers, social care organisations, local authorities and commissioners.

Adherence to the MHA and the MHA Code of Practice

At the time of the inspection, ten patients were receiving care and treatment under the Mental Health Act.

Sixty seven per cent of staff had received training in the Mental Health Act and the Mental Health Act Code of Practice.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

The Mental Health Act manager completed audits on the application of the Mental Health Act and Code of Practice.

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

Patients had easy access to information about independent mental health advocacy and staff supported patients who lacked capacity by referring to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand using easy read information, repeated as necessary in accordance with the Mental Health Act Code of Practice and recorded it clearly in the patient's notes each time.

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

Staff stored copies of patient's detention papers and associated records correctly and staff could access them when they needed to.

Staff completed detention paperwork correctly and kept copies in patient notes for staff reference.

Good practice in applying the MCA

At the time of inspection, one patient was receiving care and treatment under deprivation of liberty safeguard authorisations (DoLS).

Eighty nine per cent of staff had received training in the Mental Capacity Act.

The provider ensured independent mental capacity advocates were available to support patients who lacked capacity. Independent mental capacity advocates are a legal safeguard for people who lack the capacity to make specific important decisions.

Registered staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could refer to the provider's The Mental Capacity Act policy, which included Deprivation of liberty safeguards if needed.

Staff assessed patients' capacity and we saw evidence of this in the notes. Staff had completed Mental Capacity Assessments appropriately, with evidence given for the judgements reached.

Staff supported patients to make decisions. The speech and language therapist supported patients with their communication difficulties when needed.

Where patients lacked capacity, best interest decision meetings took place for significant decisions.

Are wards for people with learning disabilities or autism caring?

Inadequate

Wards for people with learning disabilities or autism

Good

Kindness, dignity, respect and support

We observed some kind interactions between staff and patients. Staff showed a good understanding of the individual needs of the patients and treated them with respect and dignity. Some staff showed passion for their work with patients and gave detailed examples of how they worked with complex patients.

Staff supported patients to attend their daily activities and their planned therapeutic programme, for example escorted leave and occupational therapy.

The involvement of people in the care they receive

Staff invited patients to the multidisciplinary team meetings. Families told us they were involved in their relative's care and treatment.

The provider used easy read leaflets with patients to review their rights and develop care plans, in a way patients would understand.

Staff used communication cards to be able to communicate more easily with patients. We observed staff using these during the inspection.

Patients had 'my care plans' completed which demonstrated involvement with patients in care plan formulation. However, of the six 'my care plan' files we reviewed, none had not been updated recently.

Patients had access to an advocacy service. Staff displayed posters on the wards with contact information.

The provider held monthly patient forum meetings on the wards. However, the minutes were brief and did not demonstrate how actions from previous meetings had been addressed.

The provider sought feedback from patients using questionnaires. These were adapted for patients with a learning disability to enable patients to give feedback. The provider took action following the feedback from the survey.

The provider sought feedback from all family members by sending out questionnaires to relatives and received five responses. The provider had received five questionnaires from relatives in February 2019. Themes included poor communication, availability of activities, incidents between patients and one positive comment about the care and treatment their family member had received. However, the provider did not take any action following receipt of feedback from relatives.

Staff invited families to Care Programme Approach (CPA) meetings.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Inadequate

Access and discharge

The provider reported an average length of stay of 2160 days for patients discharged in the last 12 months between 01 November 2017 and 02 November 2018. Patients had long lengths of stay.

The provider reported that patients had regular care and treatment reviews (CTR) and produced a list of dates to show this. However, out of eleven patients there were nine recorded dates of CTR meetings being held for patients. We requested the minutes of all the latest CTR reviews for all patients. The provider was unable to provide all minutes and provided three for our review. The provider told us that minutes were not always sent to them following meetings. We were concerned that there were no record of actions following the meetings for all patients. We were therefore, not assured that the provider was achieving actions to support patients towards discharge. However, staff recorded multi disciplinary meetings where CTR meetings and discharge planning were discussed.

At the time of inspection, there were 11 patients receiving care and treatment at the hospital. The hospital is registered for 15 patients. Therefore, there were beds available to admit patients.

Patients could access the service following a referral, assessment and funding agreement. At the time of the inspection, patients within the service received funding from eleven different clinical commissioning groups.

Inadequate

Wards for people with learning disabilities or autism

The provider supplied data for bed occupancy, which showed 96.6% for the six months between 01 May 2018 and 01 November 2018.

The provider reported an average of five to seven days from initial referral to assessment for patients referred to the hospital and 30 days from assessment to onset of treatment.

Staff kept beds available for patients when they returned from leave. Patients were not moved between wards during an admission episode.

Managers monitored the number of delayed discharges. There was one patient with a delayed discharge during the time period from 01 January 2017 to the date of our inspection on the 05 February 2019. This was due to awaiting on a decision from the ministry of justice.

The facilities promote recovery, comfort, dignity and confidentiality

The provider had a full range of rooms and equipment to support care and treatment for patients. There was a skills kitchen for people wanting to prepare or cook food for themselves or their visitors, a large art room where patients could enjoy a range of creative table-top crafts, an IT room, and a sensory room. However, staff told us the sensory bubble machine required repair at the time of our inspection.

All patient bedrooms had en-suite facilities.

Patients had access to their bedrooms at all times. Staff kept bedrooms locked, however patients could hold their own keys subject to risk assessment. Staff opened bedroom doors on request.

Patients were receiving interventions as detailed in their care plans, for example staff supported patients to learn skills in the occupational therapy kitchen to prepare for discharge.

Patients had access to computers. Staff completed display screen risk assessments and patients were encouraged to use skype to talk with family and friends.

There were quiet areas on the ward for patients to see visitors.

The provider had a mobile phone in the office. Staff made this available to patients for private conversations.

Patients had access to outside space. The hospital was set in a 30-acre site, and there was access to secure outside space for both wards.

Patients had access to hot and cold drinks, and snacks throughout the day. Staff used pictorial menus so they could support patients to choose their meals.

Patients were able to personalise their bedrooms if they wished.

Patients had access to lockable storage within their bedrooms. Patients were able to hold their own keys, subject to risk assessment.

The provider had an activity programme displayed in ward areas and in patient notes. The occupational therapy team provided activities from Monday to Friday and ward staff facilitated activities at weekends.

Staff supported patients to maintain contact with their families and carers. The hospital had a visitor's room for patients to use outside of the ward areas.

Meeting the needs of all people who use the service

The service could support and make adjustments for people with disabilities, communication needs or other specific needs.

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

The service had information leaflets which staff could make available in a variety of languages and easy read versions, if needed.

Managers made sure staff and patients could arrange interpreters or signers when needed.

Patients had access to spiritual, religious and cultural support. Staff supported patients with sexuality and ethnicity as required.

Listening to and learning from concerns and complaints

The provider reported that 15 complaints had been received in the previous 12 months to October 2018. Fourteen of the complaints were partially upheld and one was on-going. During the inspection we reviewed eight complaints between the dates of 08 October 2018 and 17 January 2019 which the provider had recorded on a complaints tracker with outcomes. We also reviewed four

complaint investigation reports. The quality of complaint investigations were poor and did not demonstrate sufficient review of evidence to conclude outcomes and issues were not always addressed. Of the four investigation reports we looked at the provider had combined the content of two investigations in to one report which did not make sense and evidence was not reviewed sufficiently to reach an outcome for the second report. Managers did not use CCTV evidence as part of their investigation in to unexplained injuries on a patient.

Are wards for people with learning disabilities or autism well-led?

Inadequate

Vision and values

The provider had a key set of visions and values for the service.

Staff told us they were aware of the provider's vision and values to make a positive difference to people and their families by delivering personalised health and social care that helps them to achieve the things they want out of life. Staff believed that this was reflected in the care provided.

Staff knew who the senior managers within the hospital were and reported that they were approachable and supportive.

Good governance

Managers had no oversight of significant issues that threatened the delivery of safe and effective care.

Issues were not always identified and adequate action to manage them was not always taken. Managers had not identified issues in the clinic room that compromised safety. This included out of date medications, excessive clinical waste and general cleanliness. The clinic door had been fixed three times but remained unsecure. Staff did not have access to oxygen and this had been the case since November 2018. Managers were not responsive to issues that compromised patient safety.

The provider had repaired and replaced staff personal alarms; however, staff continued to raise concerns that their alarms did not always work effectively.

Managers had not addressed, in full, issues raised in previous inspections regarding patient observations. We observed staff leave two patients unattended who required constant observations within close proximity at all times. The provider had previously received a requirement notice for this breach at a recent focused inspection.

Managers did not ensure they equipped staff with the right skills for their role. Staff were not up to date with mandatory training. The provider used a training matrix to record and track compliance with training. Training topics which did not meet the providers target of 80% included: safeguarding children (74%), medication management (70%), food safety (72%), fire warden (33%) mental health act (67%) care certificate 59%), legionella (67%) and epilepsy training (71%).

Managers did not offer appropriate levels of support to staff. Staff supervision rates were 50% and appraisal rates were 21%.

The service had high vacancy levels for support workers. However, the provider utilised block booked agency staff or bank staff to ensure safe staffing levels on wards.

Staff were able to maximise their time on direct care activities. Staff spent much of their time in the ward areas engaging with and supporting patients.

Staff completed audits on the use of anti-psychotic medication and physical healthcare.

The provider had recently requested a visit by an expert by experience to provide feedback on the service. The feedback included issues about the wards having a poor décor and ambience; poor cleanliness of the kitchen areas and some poor communication observed from staff to patients with a learning disability.

Managers could not monitor the use of restraint effectively. Staff reported incidents using the provider's electronic incident reporting system. However, staff did not always record physical restraints used during incidents. We found three incidents where staff did not record the type of physical restraints used during an incident. The information used to monitor restraint was inaccurate.

Staff had input into the local risk register, which was linked to the provider's risk register. Staff were aware of the process for reporting risks.

Clinical governance was not integrated to support decision-making. Clinical governance meetings did not take place regularly.

The provider followed safeguarding procedures and maintained contact with the local authority during investigations. The provider was currently being investigated by the local authority for an organisational safeguarding alert due to reports of alleged abuse by staff towards patients.

Leadership, morale and staff engagement

Staff gave feedback via their staff survey. We reviewed the latest staff survey results from December 2017, which identified areas for improvement. This included job satisfaction, health and wellbeing, incidents, safeguarding training, development, appraisals and supervision.

The provider supplied data that showed a staff sickness rate of 8.3% between 01 July 2017 and 01 November 2018.

Staff were aware of the provider's policy for whistleblowing and told us they felt confident to raise concerns without fear of victimisation. Managers told us that several staff had recently raised concerns about the behaviours of colleagues towards patients and were in the process of investigating. Managers said they supported and encouraged staff to raise concerns. We saw evidence of staff concerns being discussed at staff meetings. Managers told us that staff raising concerns had led to further staff coming forward to raise concerns which were being supported by managers.

Staff feedback to the recent increase in staffing numbers and modifying the daily staffing allocation was mixed. Some staff felt this had improved morale. They could now generally have a break from observations and they worked throughout the whole hospital instead of within specific units. However, some staff did not believe there were enough staff to cover breaks for all staff or to enable all staff to leave patient observations at the end of their allocated time.

Managers had not taken effective steps to reduce staff anxiety regarding working with a particular patient. Some staff raised concerns about feeling fearful and anxious of working with one patient due to their aggression and previous accusations of abuse against staff. Whilst on site, we witnessed three occasions of staff either not intervening or reluctantly so in dealing with incidents of aggression towards others, including inspection staff. We raised this with the managers who said they were aware that staff were fearful of accusations and aggression from this patient. This was despite training being offered in the patients' positive behavioural support plan and patient boundaries.

The provider had experienced extensive issues retaining a registered manager for the service. At the time of the inspection, a new manager was in post and was in the process of applying for their CQC registration. The provider last had a registered manager in post in January 2018.

Commitment to quality improvement and innovation

The provider did not identify its membership to any accreditation schemes. There was little innovation or service development.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the environment is adequately maintained and decorated.
- The provider must ensure staff record physical interventions used during incidents.
- The provider must ensure that personal alarms and the alarm panels are repaired.
- The provider must ensure that all staff receive regular appraisals, supervision and are up to date with all mandatory training.
- The provider must ensure that staff maintain the CCTV and correct the timings on the system.
- The provider must ensure the clinic room, equipment and medication is managed safely.
- The provider must ensure staff complete enhanced observations in line with patient care plans and the provider's observations policy.
- The provider must ensure they have adequate oversight of significant issues and take action to manage these.
- The provider must ensure they complete adequate investigations following complaints and use all available evidence.
- The provider must ensure that actions recommended from care and treatment reviews are recorded clearly and are easily accessible.

Action the provider SHOULD take to improve

- The provider should ensure that actions are taken following patient feedback in patient forums.
- The provider should ensure that systems to manage patient care records are easily accessible.
- The provider should ensure that actions are taken following feedback from relatives questionnaires.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had not maintained the CCTV to ensure accurate timings.** **This is a breach of 15(e)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not ensure that actions recommended from care and treatment reviews were recorded clearly and were easily accessible.** **This is a breach of 17(1)(2)(c).**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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 The provider did not maintain the clinic room, medication or equipment safely. This is a breach of regulation 12 (1) (2) (a)(b)(e)(g) The provider did not ensure staff completed enhanced observations in line with patient care plans and the provider's observation policy. This is a breach of regulation 12 (1) (2) (a)(b) The provider had not ensured the environment was adequately maintained or decorated. This was a breach of 12(1)(2)(a)(b) The provider had not ensured staff recorded all physical restraints following incidents. This was a breach of 12(1)(2)(a) The provider had not ensured personal alarms and the alarm panels were repaired. This is a breach of 12(1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
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 The provider did not ensure all staff had received supervision. This was identified at the inspection in December 2016. The provider had not ensured that all staff received appraisals. This was identified at the inspection in December 2016. The provider had not ensured that all staff were up to date with all mandatory training. This is a breach of 18(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had poor oversight of significant issues and adequate action to manage them was not always taken. The provider did not complete adequate investigations following complaints and use all available evidence. This is a breach of regulation 17 (1) (2) (a)(b)