Cheswold Park Hospital

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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.

Overall summary

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

- The provider did not have effective systems and processes to identify issues in infection control and incident management. Staff displayed poor hand

Summary of findings

hygiene and infection control practices. They had not identified all risks in an infection control risk assessment and this did not contain sufficient information to manage and mitigate risks.

- The provider had not taken timely and reasonable steps to assess, monitor and mitigate the risks to the physical health of a patient. Care and treatment records did not contain mental capacity assessments when making decisions about some aspects of physical health.
- The patient risk assessment did not identify all risks and the risk management plan did not address and mitigate risks. Staff did not discuss risks at staff handover.
- Care plans did not contain enough detail to reflect the care required and staff had not involved the patient in their development. Staff did not always follow the patient's communication care plan. They did not have immediate access to the patient's records, as these were stored in an office away from the suite.
- In over half of the incidents of restraint used, it was not proportionate or in response to risk. Staff that reviewed incidents did not make recommendations, record actions or lessons learnt after incidents. The provider did not have effective systems to have oversight of incident management and did not identify these issues.
- Not enough dedicated staff were available when needed and this meant that the patient had to wait staff to be available to enter the suite or get items that they needed. There continued to be limited input from some disciplines of the multi-disciplinary team.
- The patient did not have privacy and dignity when using the bathroom or holding telephone calls.
- The secure garden did not contain a shelter from adverse weather.
- Senior management staff lacked understanding about the use and application of positive behavioural support. They acknowledged that they did not currently have any expertise in adaptive behavioural scales, applied behaviour analysis or positive behaviour support within their substantive staff.
- The registered person did not speak respectfully when they described a patient and their needs.
- Training in learning disability and personality disorder was not up to date.

However, we found the following areas of positive practice:

- Since our last inspection in February 2017, the provider had installed a handwashing sink and a drain in the suite. They had arranged for an external hospital to review the long-term segregation every three months.
- Staff entered the suite more frequently and for longer duration and the suite was more personalised and contained some furniture.
- The provider had commissioned a sensory integration assessment.
- Staff who regularly worked with the patient knew the patient well, treated them with respect, praised and encouraged them.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards		

Summary of findings

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Summary of this inspection

Background to Cheswold Park Hospital

Cheswold Park Hospital is a purpose-built hospital in Doncaster. Riverside Healthcare Limited is the service provider. The hospital provides low and medium secure accommodation. It provides services for men with mental disorders and an offending background or whose mental health needs require assessment, treatment and rehabilitation within a secure environment. Patients are aged between 18 and 65. The hospital has the capacity to provide care and treatment for up to 109 patients detained under the Mental Health Act.

The hospital is registered with the Care Quality Commission to provide the following regulated activities:

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

The hospital has a registered manager. It has five low and three medium secure wards and an autism spectrum disorder service that consists of a five-bed annex and a long-term segregation suite.

The wards are:

- Aire 12-bed low secure mental illness assessment
- Brook 15-bed medium secure mental illness/ personality disorder
- Calder 16-bed low secure personality disorder rehabilitation
- Don 12-bed low secure personality disorder assessment
- Esk 12-bed low secure mental illness
- Foss 12-bed low secure mental illness
- Gill 12-bed medium secure learning disability and annex Wilton Unit five-bed autism spectrum disorder unit.
- Hebble 12-bed medium secure learning disability
- Wilton unit
- A one-bed long-term segregation suite.

We last inspected Cheswold Park Hospital in February 2017. After that inspection, we rated it as overall inadequate. We rated safe as inadequate, effective as inadequate, caring as requires improvement, responsive as requires improvement and well-led as inadequate. The provider had not received our draft report and we had not published the report prior to this most recent inspection.

Following our last inspection in February 2017, we issued the provider with one warning notice in relation to a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At that inspection, we found that the registered person had failed to carry out their statutory duty to notify the Care Quality Commission of notifiable incidents.

We also issued the provider with eight requirement notices in relation to breaches of the Health and Social Care Act. These related to:

- Regulation 9 Person centred care
- Regulation 11 Need for consent
- Regulation 12 Safe care and treatment
- Regulation 13 Safeguarding service users from abuse and improper treatment
- Regulation 15 Premises and equipment
- Regulation 17 Good governance
- Regulation 19 Fit and proper persons.

Our inspection team

This inspection was led by Honor Hamshaw, Inspector, Care Quality Commission.

The team that inspected the service comprised five CQC inspectors, two CQC inspection managers, one CQC Head of Hospital Inspection and one specialist advisor. The specialist advisor had a background in mental health and learning disability nursing.

Summary of this inspection

Why we carried out this inspection

The Care Quality Commission is a part of the United Kingdom's National Preventive Mechanism designated under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.Optional Protocol to the Convention against Torture and other Cruel Inhuman or Degrading Treatment or Punishment is an international human rights treaty designed to strengthen the protection of people deprived of their liberty. It acknowledges that such people are particularly vulnerable to ill-treatment and advocates that efforts to end ill-treatment focus on prevention through a system of independent and regular visits to all places of detention.Our visits in England to mental health units where patients may be deprived of their liberty are a necessary part of our National Preventative Mechanism activity.

We completed a comprehensive inspection at Cheswold Park Hospital in February 2017. During this inspection, we identified concerns about the care and treatment provided in the one bed long-term segregation suite. This focussed inspection was in response to these concerns and to identify if the provider had made improvements to the care and treatment provided since our last inspection.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location. Based on this information we considered our previous findings from our last inspection in February 2017 to remain valid about other areas of the hospital. Therefore, this inspection focussed on the one bed long-term segregation suite at Cheswold Park Hospital.

This inspection was unannounced which meant that the provider did not know we would be visiting to inspect.

During the inspection visit, the inspection team:

- visited the suite, looked at the quality of the ward environment and observed how staff were caring for one patient
- spoke with one patient who was using the service
- spoke with the registered manager
- spoke with 16 other staff members; including six staff who worked in support worker, senior support worker and assistant practitioner roles, one nurse, one social worker, the head of psychology, an assistant psychologist, an assistant occupational therapist, a ward manager, an associated specialist doctor, a responsible clinician, the director of quality, risk and compliance and the hospital's training manager
- spoke with three external staff including a speech and language therapist, a consultant clinical psychologist and an independent learning disability nurse consultant
- spoke with an independent mental health advocate
- attended and observed hand-over meetings and two multi-disciplinary meetings
- looked at the care and treatment records
- carried out a specific check of the medication management
- carried out a continuous observation of the care and treatment of the patient
- completed five short observation framework for inspections (SOFI).
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with one patient using the suite. They told us that they liked staff and about an activity they enjoyed. They also named a staff member who helped them clean.

The patient knew the names of their advocate and their doctor. They said that they had plenty of food to eat. They also told us how they relaxed and about some activities they enjoyed.

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?

This was a focussed inspection in relation to concerns about care and treatment provided at the one bed long-term segregation suite. Ratings have not been given for this inspection.

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

- Staff displayed poor hand hygiene and infection control practices. They did not wash their hands or clean an unsanitary hatch prior to serving food through it. Staff did not wear disposable aprons when appropriate and they used different coloured mop and buckets to clean the same area. This practice did not promote preventing the spread of bacteria and infections.
- Staff had not identified all potential infection control risks in the risk assessment for the suite. Staff completed weekly environmental checks. However, the provider did not review staff practice to assess adherence to effective infection control and hand hygiene principles.
- The patient risk assessment did not identify all of the patient's risks or contain sufficient and detailed information to show how staff managed and mitigated risk. When working alone, staff did not follow documented procedures for interacting with the patient.
- Staff did not the review the patient's risk assessment following incidents.
- Staff used restraint that was not proportionate or in response to risk in over half of episodes of restraint.
- Incident report forms had missing information such as, initial and residual risk scores and the full information discussed in debriefs. Staff who reviewed incidents did not record any recommendations, most forms did not contain any further actions required and none contained any evidence of lessons learned.
- The patient's positive behavioural support plan was basic and staff lacked understanding about the use of positive behavioural support in practice.
- The patient had to wait each time for enough staff to be available to facilitate entering the suite to do an activity or task.
- Training in learning disability (64%) and personality disorder (67%) had low compliance rates.

However, we found the following area of positive practise:

Summary of this inspection

- Since our last inspection in February 2017, the provider had made improvements to the facilities of the suite. They had installed a handwashing sink and a drain into the floor. Staff entered the suite to complete cleaning more frequently.

Are services effective?

This was a focussed inspection in relation to concerns about care and treatment provided at the one bed long-term segregation suite. Ratings have not been given for this inspection.

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

- Staff had not taken timely action to try to obtain physical health checks and monitoring to assess potential side effects of medication and screen for other physical health conditions.
- The care and treatment records contained 18 care plans. However, these care plans did not reflect the care that staff provided. They did not contain detailed strategies and approaches for staff to deliver the care and treatment the patient required.
- The patient's care and treatment records did not contain evidence that staff had assessed the patient's mental capacity when making some decisions about treatments.
- Not enough dedicated support and nursing staff were available. This meant that there was not enough staff available to meet the patient's needs as soon as required.
- Staff stored the patient's care and treatment records in an office, which was not accessible to staff easily.
- Although input from psychology had increased; there continued to be limited input from psychology, occupational therapy and speech and language therapy.
- The provider's mandatory training did not meet seven of the 15 standards of the care certificate.
- Staff did not discuss risk including changes to risk assessments or care plans during handover meetings.

However, we found the following areas of positive practice:

- Since our last inspection in February 2017, the provider had contracted an external agency to complete a sensory integration assessment of the needs of the patient.
- Progress records showed that improvements had been made with staff having more entries into the suite that were positive for longer durations without using restraint.
- The provider had arranged for an external hospital to review the long-term segregation of the patient every three months in line with the Mental Health Act code of practice.

Summary of this inspection

Are services caring?

This was a focussed inspection in relation to concerns about care and treatment provided at the one bed long-term segregation suite. Ratings have not been given for this inspection.

We found the following areas of positive practice:

- Most interactions between staff and the patient were positive. Staff provided praise, encouragement and treated the patient with respect.
- Staff who worked regularly with the patient knew them well and the patient responded more positively.
- Staff had made improvements by increasing the frequency of occasions on which they entered the suite. Staff actively prepared to enter the suite throughout the inspection to engage with the patient. One entry was successful and staff engaged positively with the patient whilst they completed cleaning tasks.
- The patient had an Independent Mental Capacity Advocate and an Independent Mental Health Advocate to represent their views about their care and treatment.

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

- Sometimes staff did not always follow the techniques directed in the patient's communication plan.
- Staff had not actively involved the patient in the development of their care plans and risk assessments.

Are services responsive?

This was a focussed inspection in relation to concerns about care and treatment provided at the one bed long-term segregation suite. Ratings have not been given for this inspection.

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

- The patient's last care and treatment review identified issues that were preventing or making the patient's discharge more difficult. The provider had not completed many of the recommendations required in line with the timescales in the action plan.
- The patient's discharge plan did not document goals or outcomes that would facilitate the patient's discharge including the recommendations from the last care and treatment review.
- The patient did not have privacy and dignity when they used the bathroom.
- Staff did not permit the patient to have telephone calls in private.

Summary of this inspection

- The secure garden did not contain a shelter from adverse weather.
- Staff served drinks to the patient at room temperature.
- The patient had to wait frequently whilst staff left the suite to get items that they needed.

However, we found the following areas of positive practice:

- Since our last inspection in February 2017, the provider had introduced some furniture into the suite. The patient had some of their personal items. The suite was more personalised with some posters, stickers and post-it notes on the walls.

Are services well-led?

This was a focussed inspection in relation to concerns about care and treatment provided at the one bed long-term segregation suite. Ratings have not been given for this inspection.

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

- The provider did not have effective systems to identify and mitigate all infection control risks practices.
- The provider did not have robust processes to have oversight and ensure that they made improvements and managed risks following incidents.
- There continued to be limited multi-disciplinary input to the suite.
- Senior management staff lacked understanding about the use and application of positive behavioural support.
- The registered person did not speak respectfully when they described the patient and their needs.

However;

- Since our last inspection, the provider had made improvements to the suite including the provision of a sink and drain in the staff observation area. They had increased staff entries including to clean the suite more frequently. The provider had commissioned a sensory integration assessment and made arrangements for an external hospital to review the long-term segregation every three months. The suite contained more furniture, personal items and was more personalised.
- Staff who worked at the Wilton Unit had developed an e-learning package to increase staff knowledge of issues which were relevant to the patient's condition and needs.

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.

Since our last inspection in February 2017, the provider arranged an external hospital to complete an independent review of long-term segregation every three months. This was in line with the Mental Health Act code of practice.

Ninety eight percent of staff had completed Mental Health Act e-learning training. Care and treatment records contained detention and consent to treatment paperwork appropriately. The record contained a valid T3 certificate that meant that a second opinion appointed doctor had approved the treatment prescribed to the patient.

The care and treatment records contained up to date leave forms for emergency leave for urgent medical treatment only.

The hospital had a central Mental Health Act office with dedicated administrators which staff could seek advice from about the Act.

The patient had an independent mental health advocate who visited the patient frequently. However, staff had not invited them to attend the patient's last mental health tribunal.

Mental Capacity Act and Deprivation of Liberty Safeguards

As part of this inspection, we did not review the Deprivation of Liberty Safeguards. The patient was detained under the Mental Health Act 1983 and therefore this did not apply.

An independent panel completed a care and treatment review in December 2016. NHS England commission care and treatment reviewed to review the care and treatment of patients with learning disabilities or autism in hospitals. The aim of these is to improve the quality of care and reduce the length of stay so that individuals do not spend longer than necessary in hospital. They assess patients care and treatment in relation to questions to assess outcomes.

They recommended that staff undertake a capacity assessment in relation to healthcare interventions. Care and treatment records did not contain evidence of mental capacity assessments for some interventions. Staff had identified some risks to physical health. Despite not completing mental capacity assessments for these decisions, staff had formed judgement about one intervention and staff had started consulting with the patient's relative regarding another intervention. This was not in line with the Mental Capacity Act.

The patient's care and treatment record contained a mental capacity assessment for understanding one intervention. The outcome of this was that the patient lacked the capacity. We did not see evidence that staff followed and documented the best interest decision-making process. However, records showed that staff would continue to assess mental capacity at intervals to review this and a desensitisation plan was in place for this intervention.

Mandatory training records submitted by the hospital did not show training compliance rates for Mental Capacity Act training. However, when we last inspected the hospital in February 2017, most staff had received this training.

Forensic inpatient/secure wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

The suite was a facility used for the long-term segregation of one patient. It was on the main corridor of the hospital. The entrance opened into a staff observation area. The suite consisted of a lounge, a bedroom and an en suite bathroom. The staff observation area had two doors that accessed the lounge and the bedroom areas of the suite. Each of these had a hatch that staff could open. The suite had viewing panels fitted so that staff could see into the en suite bathroom and lounge. The suite did not have an intercom system and staff communicated with the patient through the door and hatches.

The environment contained ligature anchor points, which included shower, sink and lights. A ligature anchor point is something that an individual could use to fix something to and harm themselves through asphyxiation. However, staff knew what these ligature points were and staff maintained regular observations. Risk assessments had been conducted and we were satisfied that these procedures were adequate for the level of risk.

The suite did not have a clinic room. Staff stored medicines and used equipment from the clinic room on Gill ward. The hospital had emergency grab bags that contained equipment and emergency drugs stored on two wards at each end of the hospital. In the event of a medical emergency, a staff member from these wards was responsible for bringing the emergency grab bags.

At our last inspection in February 2017, we raised concerns regarding the cleanliness and the environment of the suite. We were concerned that the hospital did not have a cleaning schedule and the suite was visibly dirty. Staff did not have access to handwashing facilities.

At this inspection, we found that the provider had made some improvements to the facility. They had installed a handwashing sink and a drain in the floor in the staff observation area. The hospital had implemented a cleaning schedule for the suite that set Mondays for cleaning the lounge and Fridays for the bedroom. However, the schedule did not state whether staff should clean the bathroom. The cleaning schedule displayed was for the previous month and cleaning tasks recorded did not always take place on Mondays and Fridays.

Staff displayed poor hand hygiene and infection control practices. Staff who performed cleaning tasks had received mandatory hand hygiene training and in infection control. Training course content for hand hygiene training was a leaflet that showed effective hand washing practice. During our inspection, between 9.30am to 11am, we maintained continuous line of sight of staff. We observed that the hatch became unsanitary and staff provided food through the hatch. Staff had not cleaned the hatch before they passed food through the hatch. At 1.30pm, we observed the hatch was cleaned using a dry hand towel and a cleaning spray and there was not a thorough clean of the entire area that was in an unsanitary condition.Staff mopped the floor of the staff observation area three times. They used a green mop and bucket once and a red mop and bucket twice. The provider's general infection control policy did not contain information about the use of dedicated mops and buckets for specific areas. After our inspection, the provider submitted an infection control protocol/cleaning protocol for the suite. This stated that staff should use a red mop head for the living room area of the suite. It did not state where staff should use the green mop and bucket.

A chair in the staff area had a wooden base and legs that had become wet. Wood is a porous material. This means it can hold liquids and this makes it more difficult to ensure that it is cleaned thoroughly.

Forensic inpatient/secure wards

None of the staff who provided care or treatment to the patient wore disposable aprons as personal protective equipment. This included at times when the provider's policy stated that they should. This did not promote hand hygiene or infection control and increased the risk of cross contamination and potential spread of bacteria and infections.

After our inspection, the provider submitted an infection control risk assessment for the suite. This risk assessment did not contain a date so it was unclear when they had created and implemented this. The risk assessment listed some potential hazards. However, this was not comprehensive, as it did not assess all risks to the health and safety of the patient that we identified during our inspection. For example, staff not following the provider's general policy on infection control for hand washing and, staff not following the infection control protocol for the suite. A weekly environmental check of the suite assessed the state of the environment and checked the equipment available. The provider did not review staff adherence to the provider's infection control procedures including wearing personal protective equipment and whether staff effectively washed their hands when appropriate.

On arrival on shift, reception staff issued staff with keys and a personal alarm. Staff wore these attached to belts. However, they told us that when entering the suite, staff removed their alarms and keys. When staff entered the suite, additional staff were always present in the staff observation area and they could intervene if necessary. Staff also had access to a radio and a telephone in the observation area to communicate with staff in other areas of hospital.

Staff told us, that when the hatch was lowered, that a minimum of two staff should be present. However, on two occasions when working alone we saw that a staff member placed both of their arms through the hatch. This meant that if they could not remove their arms from the hatch that they would not be able to call for assistance. The patient risk assessment had not identified this as a risk.

Safe staffing

Staff told us that two support staff worked on shift each day and night. Records submitted by the provider for the last three months showed that a team was on shift to cover the suite and the Wilton Unit. Information submitted by the provider confirmed that they prioritised two staff per shift during the day and night for the suite. During our inspection, at 6am there was one support staff working in the suite. They told us that this was due to sickness absence across the hospital site. However, at 7am an additional support staff arrived on shift. Two support staff arrived on day shift staff and the night shift on the day of our inspection.

The hospital had two qualified learning disability nurses that worked supernumerary across the suite and another ward. These nurses did not work on shift at the suite.

When staff entered the suite, they told us that this required four members of staff for a suite entry and five members of staff for access to the garden area of the suite. The hospital did not have additional staff on shift specifically for the suite so this was facilitated using existing staffing resources from other wards, the ward manager, the supernumerary qualified nurses and other staff within the hospital available if needed. This meant that when the patient wanted staff to enter the suite to clean or to complete an activity including going outside into the garden that they had to wait for the staff to be available to facilitate this request.

A doctor visited the patient each day and staff told us that they could access an on-call doctor if needed.

Mandatory training consisted of face-to-face training including: No Force First, immediate life support for registered nurses, basic life support for support staff, searching patients, safeguarding, duty of candour and hand hygiene. In addition, mandatory e-learning including: health and safety including fire, Mental Health Act, security, information governance, equality and diversity, learning disabilities, personality disorder, cardio metabolic. Cardio metabolic concerns both heart disease and other metabolic disorders such as, diabetes. The overall training compliance rate was 85% for staff that worked in the suite. The lowest compliance rate was for the e-learning training in learning disability and personality disorder at 64% and 67% respectively.

Assessing and managing risk to patients and staff

The hospital used the functional analysis of care environments risk assessment tool. Staff last reviewed the patient's risk assessment two months prior to our inspection. Since this date, staff reported a number of incidents involving the patient; staff had not reviewed the patients' risk assessment in response to these incidents.

Forensic inpatient/secure wards

Staff had not assessed the risks of the long-term segregation of the patient including the risk of institutionalisation. The patient's risk management plan did not contain sufficient and detailed information to show how the risks to the health and safety of the patient were mitigated. It did not identify how the risks including: any risk to staff, lack of monitoring the physical health and the risk of institutionalisation were managed and mitigated.

The episode of long-term segregation commenced when the patient was admitted to the hospital several years ago. Between 12 December 2016 and 23 May 2017, there were a number of episodes of restraint.

The incident report forms for nearly half of the episodes of restraint showed that staff commenced restraint that was not proportionate or in response to the level of risk.

The provider had not analysed the trend in incidents of restraint and use of when required medication to take into account wider contextual factors beyond the time the patient had spent in the suite. For example, at our last inspection in February 2017 where we raised concerns about that staff did not enter the suite frequently. During our inspection, the patient asked for as and when required medication and staff did not administer this.

Care and treatment records contained a basic positive behavioural support plan. This plan provided some descriptions of the known types of behaviour and gave some actions that staff could take to support the patient to remain calm and relaxed. It also contained actions to de-escalate and reactive strategies where challenging behaviour was displayed. The positive behavioural support plan was not formulated from functional assessment of behaviour and staff did not record observations and data for the purposes of evaluating and reviewing the plan and strategy of support. The plan did not provide the detail and information as recommended by guidance from the National Institute of Health and Care Excellence. In practice we saw that staff did not always follow the positive behavioural support plan as we saw that the 'now and next' board was not used and the weekly menu had not been completed.

The multi-disciplinary team, registered person and representatives from the senior management team delivered a presentation on the patient's care and treatment. When asked about the use of positive behavioural support they could not explain how positive behavioural support worked in practice as the organisation used a No Force First restraint approach. Staff did not recognise that positive behavioural support was a holistic approach to working with the individual and identified this as a de-escalation technique prior to using restrictive interventions.

The hospital had a long-term segregation booklet that staff used for recording of observation and reviews of the patient. Staff completed regular entries to record information. However, during our inspection we saw that staff did not always record the behaviours that the patient displayed each time.

All staff received training in safeguarding as part of their mandatory training.

Track record on safety

The provider reported that no serious incidents relating to the suite in the last 12 months.

Reporting incidents and learning from when things go wrong

The hospital had an electronic incident report system. Between 12 December 2016 and 17 May 2017, records showed that the majority of incident reports did not have either initial risk ratings or residual risk ratings. Staff that had recorded risk ratings had completed these inconsistently. Staff reported incidents similar in nature as a "rare" or "possible" likelihood of reoccurring. These included the incidents where staff had completed a planned restraint.

Staff completed a debrief after each episode of restraint. Most debriefs focussed on the restraint and not the antecedent events or the rationale for using restraint. This meant that staff did not reflect on the events leading up to using restraint and their decision to implement restraint. Records did not always reflect the discussions held. Staff recorded two debriefs as "no issues raised" and "few points to address". This meant that staff reviewing incident reports would not have the details on positive areas discussed or information to know what action they should take to address any issues identified.

Half of the incident report forms recorded that staff completed a debrief with the patient. However, most of

these did not contain any information relating to the discussion that took place or any views of the patient. The remaining incident reports stated that staff did not complete a debrief with the patient.

The ward manager reviewed all incidents and the restraint trainer also reviewed incidents involving restraint. Incident report forms contained sections to record recommendations, training needs, actions required, lessons learnt and openness and transparency. However, out of the incident forms reviewed, none contained any evidence or recommendations relating to training needs, lessons learnt or openness and transparency. Three incident reports stated that an action to take was a multi-disciplinary review but staff did not record any further information.

Are forensic inpatient/secure wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

The patient was admitted to the service several years ago. Staff did not complete a physical examination on admission and they told us this was due to the presentation of the patient.

Since admission, staff had not undertaken ongoing monitoring of physical health. Staff had obtained two physical health measurements on one occasion. One of these was outside the normal range and this had not been repeated or monitored further. The patient's care and treatment review completed in December 2016 recorded that the hospital needed to start and take innovative approaches and complete health monitoring. Records showed that doctors were consulting with the patient's relative to gain their views on a plan for treating a physical health matter. The care and treatment records did not contain evidence of a mental capacity assessment of the patient for understanding and making this decision.

In the case of another intervention, records showed that the view of the clinical team was that this would need to be completed under restraint. It was not clear how staff had made this judgement and we saw no evidence that staff made this judgement or completed the relevant assessments of capacity in line with the Mental Capacity Act. The treatment records did not contain plans to show how this goal would be achieved. The lack of physical health monitoring was not in accordance with baseline and ongoing physical health checks to assess side effects guidance from the National Institute for Health and Care Excellence.

Since the patient's admission, staff had not weighed the patient. In the time between our last inspection in February 2017 and the most recent inspection in May 2017, staff had used a measurement of the mid upper arm circumference and the malnutrition screening universal tool to estimate the patient's weight. The patients' care and treatment record contained a basic desensitisation plan to try to work towards the patient being weighed using weighing scales. At the time of our inspection, staff had not started to implement this. The patients' care and treatment records contained no information to show how staff had attempted to weigh the patient or of any issues in obtaining the patient's weight that would require a desensitisation plan.

The patient's care plans lacked detail on strategies and approaches to supporting the patient and developing their potential for recovery and skill development. The care and treatment records for the patient contained 18 care plans that applied to a range of areas of care and treatment that included physical health, legal care, activities and hobbies, social, positive behavioural support and medication. Most of these areas had multiple care plans. For example, six care plans related to physical health and three related to the patient's legal care under the Mental Health Act. Nursing staff were in the process of developing an additional care plan for introducing furniture, staff entering the suite and for another proposed approach to support the patient. Staff regularly reviewed the care plans. However, the care plans did not provide sufficient and meaningful information about what actions staff should take to support the patient. For example, where staff should stand and what they should do. We saw that regular staff knew the patient well and mostly provided positive support. Staff had started to engage with the patient to assist their development in a specific way. We saw that staff facilitated this in an appropriate and positive way with the patient. However, this was not recognised or recorded in the patient's care plans. This meant that with any staff changes, staff following the patient's care plans might deliver different care.

Staff who worked in the suite had immediate access to the current long-term segregation records pack and a grab file

that contained some documents. The remaining care and treatment records which included the care plans and risk assessments were stored in the staff office of another unit. This was situated down the main hospital corridor from the suite away from the suite. Staff working with the patient would not have immediate access to these records.

Best practice in treatment and care

Doctors prescribed medication to the patient. They told us that some of the use of medication was not in line with guidance, but that this was in accordance with the patient's circumstances and had coincided with measured reduction in intensity and frequency of behaviour.

Following our last inspection in February 2017 where we raised concerns about the provision of psychological interventions for the patient, staff told us that the hospital had increased the contact that the patient had with clinical psychology staff.

Staff did not record events prior to and after events involving the patient's behaviour occurring and we observed that staff did not always record each time the patient engaged in problematic behaviour. This meant that the data collected would not contain sufficient detail for a functional analysis of behaviour.

Since our last inspection in February 2017, the hospital had commissioned an external agency to complete a sensory integration assessment of the patient. At the time of our inspection, this was in the early stages. The hospital did not have a timescale for this to be completed.

The patient's care and treatment records did not contain evidence of routine physical health interventions for example, regular GP, optical or dental check-ups.

Staff mainly measured outcomes by reviewing amount of restraint, use of as and when required medication and frequency of other behavioural issues. Charts showed that the frequency had changed, however, staff that we spoke with could not explain how or why these changes had occured and they did not recognise the wider context. A new progress report showed more recent outcomes measured between 04 May and 13 May 2017. This showed that the hospital had introduced more furniture, staff entered the suite more frequently for longer and staff had entered the suite to clean without using restraint.

Skilled staff to deliver care

The hospital had a funding agreement in place with a clinical commissioning group for the care and treatment of the patient in the suite.

In addition, the funding agreement stated that the patient would have access to the full range of professions within the multi-disciplinary team including psychiatry, psychology and occupational therapy on a sessional basis.

The suite did not have a dedicated staff rota. The rota in place covered the Wilton unit and the suite. We reviewed rotas between 1 March 2017 and 31 May 2017 and these showed that number of staff on shift for the Wilton Unit and the suite. The provider told us that two staff each day and night were prioritised to the suite and confirmed that these staff worked in support worker, senior support worker or assistant practitioner roles. We saw that this meant that that there were not enough dedicated staff available to facilitate room entry or garden access when required and the patient had to wait for staff to be made available from other areas of the hospital.

The rota for the Wilton Unit and the suite showed that between 1 March 2017 and 31 May 2017 that registered nursing staff worked 19 day shifts and no night shifts. However, none of these staff had been dedicated to work at the suite. This meant that when the patient required medication that they had to wait for a nurse to be available from another area of the hospital to administer their medication.

A ward manager was responsible for the Wilton unit and the suite.

The hospital had external professionals including a speech and language therapist and an independent learning disability nurse consultant who worked at the hospital for one day per week. Their input was not dedicated to the suite.

Although input from clinical and therapeutic specialists had increased since our last inspection in February 2017 this continued to be limited. We were told that the hospital were in the process of further recruitment. Some therapeutic interventions were delivered by an assistant who did not have a qualification in that therapy.

Other disciplines that worked with the patient included a responsible clinician (a consultant psychiatrist), an

associate specialist doctor and a social worker. Since our last inspection in February 2017, the hospital had commissioned an external agency to start and complete a sensory integration assessment.

The provider's mandatory training did not meet seven out of the 15 standards in the care certificate which included: infection prevention and control, awareness of dementia, fluids and nutrition, privacy and dignity, communication, working in a person centred way and duty of care.

The hospital had provided 31 out of 37 of staff working across the Wilton unit and the suite with two days of training in autism spectrum disorders. Staff who worked at the Wilton Unit and suite formed one team. However, the assistant forensic psychologist and assistant occupational therapist had not received training in autism spectrum disorders.

Multi-disciplinary and inter-agency team work

We observed staff changeover at the suite in the morning. This was short and limited information was handed over from staff leaving shift to those commencing shift. At the evening handover meeting, staff discussed the events of the day; but, they did not discuss risk to or from patients including changes in risk, care plans or risk assessments.

Staff told us that they had regular visits and involvement from the patient's external care co-ordinator at meetings about the patient's care and treatment. The patient had an independent mental health advocate that usually attended multi-disciplinary meetings.

The last care and treatment Review took place in December 2016.

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

Ninety eight percent of staff working across the suite and the Wilton Unit had completed Mental Health Act e-learning training.

Care records contained Mental Health Act documentation that was in order and stored appropriately. The records contained a capacity to consent to treatment assessment. The outcome of this was that the patient lacked the capacity to consent to some aspects of treatment. A valid T3 certificate was in place for the medicines prescribed in relation to this condition. A second opinion appointed doctor issues a T3 certificate to approve the treatment prescribed where detained patients cannot or will not consent. The patient had three care plans in place in relation to detention under the Mental Health Act. These included my rights, legal care and capacity to consent to treatment. Records showed that the staff regularly informed the patient of their rights in line with section 132 of the Mental Health Act. The care and treatment records contained up to date leave forms for emergency leave for urgent medical treatment only.

The hospital had a central Mental Health Act office with dedicated administrators which staff could seek advice from about the Act.

The patient received care and treatment under long-term segregation. Since our last inspection in February 2017, the hospital had made arrangements for the review of the long-term segregation by an external hospital every three months as outlined in the Mental Health Act code of practice.

The patient had an independent mental health advocate who visited the patient frequently. However, staff had not invited them to the patient's last mental health tribunal.

Good practice in applying the Mental Capacity Act

Mandatory training records submitted by the hospital did not show training compliance rates for Mental Capacity Act training. However, when we last inspected the hospital in February 2017, 93% of staff had received training in the Mental Capacity Act.

The patient was detained under the Mental Health Act and therefore we did not review Deprivation of Liberty Safeguards as part of this inspection.

Since our last inspection, staff had referred for the involvement of an independent mental capacity advocate. They had started to work with the patient in the month prior to this most recent inspection when considering a potential transfer to another provider.

An independent panel completed a care and treatment review on the patient's care and treatment in December 2016. One of the recommendations following this was that staff undertake a clear capacity assessment to in relation to healthcare interventions. Following our last inspection, staff had assessed the patient's capacity to understand one intervention. The outcome of this was that the patient lacked the capacity. We did not see evidence that staff followed and documented the best interest

decision-making process. However, records showed that staff would continue to assess capacity at intervals to review this and a desensitisation plan was in place for this intervention. We did not see evidence of other mental capacity assessments in relation to other physical health checks and monitoring.

Are forensic inpatient/secure wards caring?

Kindness, dignity, respect and support

During our inspection, we completed an observation of staff and patient interactions between 6am and 10pm. We also completed a series of five short observational frameworks for inspection observations. The short observational framework for inspection is a tool used to collect evidence about staff interactions to understand the experiences of people who use services in cases where they may not be able to describe these themselves.

Interactions between staff and the patient were mostly positive with some neutral and poor interactions at times. Staff that worked with the patient regularly knew them well and treated the patient with respect. Some of the negative interactions differed from the patient's communication plan.

We last inspected the hospital in February 2017. At that inspection, we were concerned that staff did not enter the suite frequently. During this inspection, we saw one staff member enter into the suite. This was in order to clean the suite. Throughout the entry, staff engaged well with the patient through clear communication and they shadowed the patient's acceptance of them in the suite. Throughout the day on various occasions, we saw that staff actively prepared to try to enter the suite to engage with the patient. This involved gathering enough staff. Some of these staff had to be released from different areas of the hospital to facilitate this. This meant that staff would not be able to enter the suite as soon as the patient would accept this.

The involvement of people in the care they receive

The patient had limited involvement and participation in their care planning, risk assessments and multi-disciplinary reviews. Staff wrote care plans in the first person and some care plans recorded some of the patient's views. However, the patient had not been actively involved in the development of these. The patient did not attend multi-disciplinary meetings about their care and treatment including, care programme approach meetings and mental health tribunals. Staff who attended these visited the patient prior to these meetings. An independent mental health advocate met with the patient to gain their views and represent these during meetings. However, the independent mental health advocate was not invited to the patient's last mental health tribunal. During our inspection, we saw a daily multi-disciplinary review that took place with the doctor and an assistant practitioner. Staff interacted with the patient as part of this review.

The patient had an independent mental health advocate. More recently, the hospital had also referred for input of an independent mental capacity advocate.

Are forensic inpatient/secure wards responsive to people's needs? (for example, to feedback?)

Access and discharge

The patient's last care and treatment review took place in December 2016. The care and treatment review rated different areas of care and treatment in relation to three categories. These categories were: discharge was being prevented or made more difficult by these issues, discharge was largely unaffected by these issues and discharge was being supported by these issues.

The reviewer identified issues that may impact the discharge of the patient and made recommendations for the hospital to complete. The issues identified and recommendations made were included:

- No central care and treatment formulation with clear timescales.
- The hospital had lacked innovation to ensure the patient was meaningfully involved in their care and treatment including providing accessible plans and involving the patient in reviewing their care plans.
- Staff had lacked creativity to obtain physical health measurements.
- The patient's risk assessment did not cover long-term risks and only involved the input of the multi-disciplinary team.
- Care and treatment records did not contain a centralised programme of reasonable adjustments and

did not adequately assess and provide interventions to reduce the patient risk to the environment. They did not contain consistent assessments of mental capacity or evidence of best interest decisions. The positive behavioural support plan did not reflect the long-term segregation or care and treatment provided. The records did not contain a communication or person centred plan and the hospital had not ensured that a sensory integration assessment was completed.

The care and treatment review set an action plan containing recommendations made. The date of the last action to be completed was April 2017. At the time of our inspection, the provider had not completed the following actions that they should have completed. They had not:

- Developed a clear centralised formalisation of the patient's care and treatment with timescales.
- Ensured that the positive behavioural support plan reflected care and treatment.
- Reviewed care plans to ensure that they reflected care and treatment provided.
- Ensured that there were assessments of capacity in relation to all physical health interventions.
- Developed a plan to promote regular opportunities for social interactions and activities or developed a desensitisation plan for access to the sports hall.
- Implemented a plan to increase physical exercise and garden access.
- Improved the evaluation of care plans.

However, since the care and treatment review, the provider had commissioned a sensory integration assessment, developed a communication plan including a grab sheet, completed a health action plan and developed some desensitisation plans to complete some interventions.

The patient had a discharge plan in place. The discharge plan contained information relating to the admission and previous historical information. It also recorded the patient's hopes for the future and provided a statement regarding the patient's care requirements. This was not dated so it was not clear when staff implemented or reviewed this. It was not clear from the discharge plan what outcomes or goals had been set to promote the patient's discharge and any provisional timescales. The plan did not refer to any other agencies for example, community teams or commissioners, involved in the progress and discharge of the patient. The recommendations made from the care and treatment review completed were not reflected within the patient's discharge plan.

The facilities promote recovery, comfort, dignity and confidentiality

The suite was made up of a lounge, bedroom and en suite bathroom. At the time of our inspection, the patient did not leave the suite to access other facilities in the hospital. However, staff told us that the hospital was in the planning stages of working towards the patient using the sports hall at the hospital.

The suite did not promote the privacy and the dignity of the patient when they were using the shower or the toilet. A viewing panel from the staff observation area did not have any ability to protect the modesty of the patient whilst using the bathroom. The restriction on their privacy and dignity was disproportionate to the level of risk towards the patient.

Visits including from relatives and advocacy took place with the visitor in the staff observation area of the suite. Staff from advocacy services told us that they would like staff to complete a risk assessment so that they could begin to conduct their visits within the suite with the patient. They felt that they had developed a rapport and that the patient now asked them to leave when they wanted the visit to end.

The patient did not have access to hold telephone calls in private. Staff in the observation area held the telephone on loudspeaker for the patient to speak with callers through the door or hatch.

A door from the lounge area of the suite opened onto a secure garden area outside. The area was not covered from adverse weather.

The patient told us that there was plenty of food. We saw that the patient was provided with a choice of what food they would like to eat. The patient had a routine of meal times and in between snacks at set points during the day. An easy read food choice board was in place. However, during our inspection, this had not been updated with the meal choice and an external staff member told us that staff

did not always complete this. We saw that staff did not display good infection prevention and control practices as they handled food without washing their hands and passed food through a contaminated hatch.

The patient had access to drinks at any time. Drinks provided consisted of two different flavours of pre-made dilute juice. This was stored in the staff observation area of the suite. It was stored on a shelf at room temperature. On the day of our inspection, it was a warm day and the patient was not provided with chilled drinks.

We last inspected the hospital in February 2017. We were concerned that the suite contained limited furnishings and was not personalised. During this inspection, we saw that the suite was more personalised. It contained a chair, footstool, beanbag and blanket in the lounge area. The bedroom contained a mattress, pillows and bedding. The lounge and bedroom areas had curtains. Walls had posters, stickers and post-it notes with pictures drawn on. The patient had some personal belongings that included various small items. Staff told us that since our last inspection, they had worked towards introducing new items.

Staff stored the patient's other personal belongings and amenities in a different location in the hospital. This included clothing, bedding and toiletries. When the patient needed something or requested something, we saw that this had an impact as they had to wait for staff to get items and this took some time. The observation area of the suite did not have sufficient space to store these items.

An occupational therapist assistant visited the patient each day to build a rapport with the patient. They completed an activity with the patient once to twice a week. Since our last inspection in February 2017, the occupational therapy assistant had started to deliver some sessions within the suite with the patient.

Meeting the needs of all people who use the service

The patient had access to some appropriate aids for the patient's morning routine to enable the patient see their morning routine in stages, a now and next board and menu choices. However, staff did not always use the now and next board or complete the menu choices board.

Are forensic inpatient/secure wards well-led?

Vision and values

The organisational values followed the six C's and an additional value of candour. These were: care, commitment, compassion, competence, communication, courage and candour.

Good governance

The provider did not have an effective system or process to monitor and mitigate the risks of or make improvements to infection control. The provider's policies on infection control, the risk assessment on infection control and environmental assessments for the suite had not identified or addressed issues that we identified during our inspection. For example, staff not washing their hands and not cleaning the hatch prior to serving food through it.

The provider did not have oversight of incident reporting. They did not have a robust system or process to evaluate incidents. They did not ensure that responses to incidents were appropriate, that recommendations were made and lessons were learnt and shared with staff. Management and restraint trainers that reviewed incident forms did not record actions, recommendations, residual risk scores and lessons learnt. The provider had not identified issues with the reporting and reviewing of incidents.

We asked the senior management team to give us a case presentation. We asked about the use of positive behaviour support in this patient's care.The team referred to 'no force first', which is their restrictive practice reduction programme.The team were not able to explain that positive behaviour support plans should be underpinned by an analysis of the function of an individual's behaviour, or that they should be used to support recovery as well as manage immediate behaviour that challenges.The team acknowledged that they did not currently have any expertise in adaptive behavioural scales, applied behaviour analysis or positive behaviour support within their substantive staff.

The provider had not ensured that clinical input had increased sufficiently since our last inspection in February 2017. However, the provider told us that they had recently recruited a specialist clinician.

Forensic inpatient/secure wards

Since our last inspection in February 2017, the provider had made some improvements. We saw that they had installed hand washing sink and drain in the floor of the staff observation area of the suite. The provider had increased the frequency that staff entered the suite including to clean the suite more frequently. The provider had commissioned a sensory integration assessment and had arranged an external hospital to review the long-term segregation of the patient every three months in line with the Mental Health Act code of practice. The provider had increased the furniture in the suite, introduced more personal items and had increased the personalisation of the suite.

Leadership, morale and staff engagement

During our inspection, when arranging for the inspection team to complete observations, the registered person spoke about the patient to members of the inspection team in a way that was not mindful or respectful of the individual patient and their needs. It did not promote the organisational value of 'compassion' towards others.

Commitment to quality improvement and innovation

Staff who worked at the Wilton Unit had developed an e-learning training package for staff who worked with patients with a specific diagnosis. The hospital had plans to make this available for staff to complete.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they have effective and robust systems to provide oversight and management of infection control.
- The provider must ensure that staff follow policies on infection control and demonstrate good infection control practices and effective handwashing .
- The provider must ensure that risk assessments relating to patient risks and infection control risks are comprehensive. These must assess all hazards and contain information to show how identified risks are managed and mitigated.
- The provider must ensure that restraint is used proportionately and in the least restrictive way.
- The provider must ensure that staff reviewing incident reports, identify recommendations, actions and lessons learnt appropriately.
- The provider must have processes in place to ensure that they have an effective system to identify shortfalls in the review and learning from incidents.
- The provider must ensure that all practicable steps are taken to assess, monitor and mitigate the risks to the health of the patient.
- The provider must ensure that staff monitor and complete checks patients' physical health regularly to identify side effects and reduce the impact on physical health from medicines prescribed for mental disorder.
- The provider must ensure that the patient and their views are included in the development of their care plans.
- The provider must ensure that care plans reflect the care being provided. They must provide sufficient information for staff to deliver care and treatment that meets patient needs.
- The provider must ensure that staff apply and follow the Mental Capacity Act and the Mental Capacity Act code of practice when making decisions.

Action the provider SHOULD take to improve

- The provider should ensure that an effective cleaning schedule is in place for the suite and staff keep contemporaneous records of cleaning.
- The provider should review staffing to ensure that sufficient numbers of staff can be deployed quickly to meet the patient's needs.
- The provider should ensure that staff training is up to date in learning disability and personality disorder.
- The provider should ensure that debriefs following incidents discuss the full incident. This should incident events leading up to the incident.
- The provider should review the storage of the suite's care and treatment records to ensure that these are accessible quickly to staff working with the patient.
- The provider should ensure that a full multi-disciplinary team with dedicated time is involved in the patients care and treatment.
- The provider should ensure that staff handovers discuss all of the relevant information including changes in patient risk and in documentation relating to their care and treatment.
- The provider should review the suite's en suite bathroom to ensure this is the least restrictive on the patient's privacy and dignity when in use.
- The provider should review the patient's access to telephone calls to ensure this is the least restrictive on their privacy.
- The provider should ensure that all staff speak respectfully about patients and their needs.
- The provider should ensure that the discharge plan includes the goals and objectives to promote the recovery and discharge of the patient.
- The provider should ensure that Independent Mental Health Advocates are invited to attend meetings about patient care and treatment including mental health tribunals.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The patient in the suite had multiple care plans that did not contain sufficient and detailed information to reflect the care and treatment that the patient required. Staff had not included this patient in the development and review of their care plans. This was a breach of regulation 9 (1) (b) (c) (3) (a) (b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: One patient's care and treatment records did not contain evidence that staff had assessed the patient's mental capacity to make decisions about some interventions. This was a breach of regulation 11 (1)(3)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: In almost half of incidents, staff used physical restraint that was not proportionate to or in response to a risk of harm on one patient in the suite. This was a breach of regulation 13 (4) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have effective systems to ensure infection control practices were upheld and to identify issues with infection control. The provider did not systems to ensure that improvements could be made and risks could be minimised following incidents. This was a breach of regulation 17 (2) (a) (b)

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 How the regulation was not being met: The provider did not ensure that care was provided in a safe way. They did not ensure that staff followed policies and staff, who worked in the suite, displayed poor hand hygiene and infection control practices. The provider had not ensured that timely and reasonable steps were taken to obtain physical health checks to monitor the side effects of medication and possible health conditions of one patient in the suite. One patient's risk assessment was not comprehensive. It did not identify all risks and did not show how all risks were managed and mitigated. This was a breach of regulation 12 (1) (2) (a) (b) (c) (d) (h).