Ash House

Quality Report

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Date of inspection visit: 3rd & 15th November 2016
Date of publication: 26/01/2017

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?	**Inadequate**
Are services caring?	**Requires improvement**
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

Overall summary

The CQC is placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made, and there remains a rating of inadequate overall or for any key question, we will take action in line with our enforcement procedures. At this point, we would begin the process of preventing the provider from operating the service. This will lead to cancelling the providers' registration at this service, or 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.

We rated Ash House as inadequate because:

- The building had blind spots that were not adequately mitigated to reduce the risk of harm to staff and patients. Staff did not know the location of emergency equipment that was available. The service did not have an environmental ligature risk assessment in place. Risk assessments and management plans were not sufficiently detailed, meaning staff did not have an adequate knowledge of patient risk. Staff were not aware of whether there was a service observation policy. Staff did not always complete safeguarding referrals to the local authority. The service had no systems or processes in place to support the safe management of medicines and their administration; staff inappropriately administered medication.
- Care plans were poor, with no long term goals or methods for achieving such goals. Psychological and occupational therapy interventions were not being delivered. Staff did not use rating scales to measure patient progress during their admission. Staff did not receive regular supervision. Staff handovers between nurses were not effective in ensuring key information regarding individual patients was shared. Multidisciplinary team meetings were insufficiently staffed to ensure holistic care was provided. Multidisciplinary meetings took place outside of normal working hours, limiting access to the meetings by relevant staff from both the service and from the community. The Mental Health Act was not adequately monitored, and no training was in place. Patients detained under the Mental Health Act did not have the relevant documentation in place in files or to hand. Patients were not read their rights whilst under detention, and advocacy services were not being accessed.
- There were no forums for patients or carers to provide input into how the service should be delivered. Staff had a limited knowledge of individual patients based on assessment shortfalls, partly due to senior management not sharing key information regarding risk with front line staff nor agency and bank staff. There were no leaflets or noticeboards outlining the treatments available to patients. There was no access to advocacy in place at the service.
- Patients did not know how to make a formal complaint. There was no information anywhere in the service outlining a complaint procedure. Activities for patients were very limited, and did not aid in patient recovery. Patients had difficulty accessing the outdoor garden area as the door was locked, and required staff to open it to go out and come in. The key-fob system utilised at the service meant that patients had to request access to corridors where their bedrooms were, and to leave the area. Admission criteria to the service was not clear, leading to the service admitting patients with complex physical and mental health needs, but staff were not adequately trained to meet those needs. The service did not consistently source an interpreter for a patient with difficulties communicating in English.
- The service did not have any vision or values. Leadership was lacking throughout the service, staff did not feel supported by the management team. Mandatory training was not monitored to ensure full compliance. Regular and appropriate staff supervision

Summary of findings

was not happening. There was a lack of medication management, as well as poor Mental Health Act Code of Practice application. The service did not use key performance indicators to gauge team performance. The service did not maintain a risk register or other system to capture significant risks that might arise. Staff meetings for all staff were not taking place, so there was little or no input from staff into the service. Staff morale was low.

However:

- We observed positive interactions between staff and patients, with staff treating patients with kindness and respect.
- Patients told us that staff were caring and genuinely took an interest in their needs.
- Carers told us that they and their family members were treated with dignity and respect.
- The service did cater for individual dietary requirements, having a separate refrigerator for halal food.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Inadequate 	

Summary of findings

Contents

Inadequate

Ash House

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to Ash House

This recently built hospital houses adults with complex mental health andpersonality disorders who may require locked rehabilitation, open rehabilitation, residential step down and community support services. It provides accommodation with24 single occupancy rooms, all with en-suite washing and lavatory facilities. The facility aims to support individuals in a highly specified manner, regarding individual needs. At the time of the inspection, there were nine patients resident at the unit, however one resident had been admitted to a general hospital, leaving eight patients on the unit.

The building operates on three floors. At the time of the inspection, only the ground floor and the second floor were in use by patients. The first floor was not in use.

This was the first inspection of the location. We also undertook a Mental Health Act review on 8 November 2016.

The regulated activities for Ash House are assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury. At the time of our inspection, there was a registered manager in place.

Our inspection team

Team leader: Lisa Bryant, inspector, Care Quality Commission.

The team that inspected the service comprised two Care Quality Commission inspection managers, two CQC inspectors and a Mental Health Act Reviewer.

Why we carried out this inspection

We inspected this service because of information received from two whistleblowers that raised concerns for the safety and wellbeing of the patients receiving care at the location.

We brought forward the announced comprehensive inspection that we had planned to complete in January 2017.

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?

Prior to the inspection visit, we reviewed information that we held about the location, as well as information received, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the environment and observed how staff were caring for patients
- spoke with two patients
- spoke with two carers of patients
- spoke with the registered manager and nominated individual
- spoke with 12 other staff members; including a consultant psychiatrist, nurses, an occupational therapist, and the head of service
- looked at 12 care and treatment records of patients

Summary of this inspection

- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients we spoke to told us that they thought the location was nice, and that staff were great. However, one patient said he had argued with staff about the lack of staff, meaning he had to wait if he wanted to go to his room.

Patients told us that staff were respectful all the time and that carers were allowed to have input into their treatment. One patient commented that he had been allowed to paint his bedroom wall the same colour as the shirt of his favourite football team.

Carers spoke highly of the service, saying they could not thank the staff enough for their help. One carer said that the service had led to a marked improvement in the behaviour of their relative, and felt that the relative could not receive better care elsewhere.

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:

- The building had blind spots that were not adequately mitigated to reduce the risk of harm to staff and patients.
- Staff did not know the location of emergency equipment that was available.
- The service did not have an environmental ligature risk assessment in place.
- Staff did not have an induction to the service. Staff did not receive training to support patients with complex and high-risk mental health issues, including offending histories.
- Staff did not have an adequate knowledge of patient risk. Patient risk assessments did not accurately identify patients' risk to self and others.
- Staff were not aware if there was an observation policy.
- Staff did not always complete safeguarding referrals to the local authority.
- The service had no systems or processes in place to support the safe management of medicines and their administration. Nursing staff had inappropriately administered a patient a medication without the necessary authority to do so.
- Some staff did not have a disclosure and barring service check before commencing employment within the service.
- The service utilised a range of blanket restrictions that were not balanced against individual patient risks.

Are services effective?

Inadequate

We rated effective as **inadequate** because:

- The service had poor medical cover to support patients' holistic care needs. Patients did not receive a physical health assessment on admission to the service.
- There were no psychological or occupational therapies available to patients.
- Staff did not use ratings scales to measure patient progress during their inpatient admission.
- Staff did not receive regular supervision or an appraisal of their work performance.
- Staff were not provided with the specialist training to perform their roles well.
- Shift handovers between nurses were not effective in ensuring key information regarding individual patients was shared.

Summary of this inspection

- The multidisciplinary team was not sufficiently staffed to ensure patients' holistic care needs were met.
- Communication within the multidisciplinary team was poor. Multidisciplinary team meetings to discuss patient care regularly took place outside of normal working hours which meant that vital members of the multidisciplinary team were routinely not able to attend.
- Staff did not adequately monitor the service's compliance with the Mental Health Act and the Code of Practice.
- Staff were not initially able to find four of the eight patients' consent to treatment forms.
- Patients detained under the Mental Health Act did not have copies of their detention paperwork filed within their individual care records.
- Staff did not consistently read patients their rights under the Mental Health Act or make the appropriate referrals to independent mental health advocacy services.

Are services caring?

Requires improvement

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

- There were no forums where patients or carers could provide input into how the service should be delivered.
- Patients had no access to independent advocacy services.
- There were no information leaflets available to patients regarding treatment options or additional support forums within the community.
- Staff had a limited knowledge of individual patients based on assessment shortfalls, partly due to senior management not sharing key information regarding risk with front line staff nor agency and bank staff

However:

- We observed positive interactions between staff and patients. Staff treated patients with kindness and respect.
- Patients told us that staff were caring and genuinely took an interest in their individual needs.
- Carers told us that staff treated patients with dignity and respect
- Most patients had a 'this is me' document on their care record, written from their perspective, which explained how best to support them

Are services responsive?

Inadequate

We rated responsive as **inadequate** because:

- Patients did not know how to make a formal complaint.

Summary of this inspection

- There was poor provision of activities within the service; there was a lack of structured activities to aid service user recovery and rehabilitation.
- Patients had difficulty accessing facilities, including outdoor space, due to the number of locked doors.
- The criteria for admission to the service was not clear. This meant that the service admitted patients with variety of complex physical and mental health difficulties that staff were insufficiently trained to support. This included patients diagnosed with Alzheimer's disease.
- The service did not consistently source an interpreter for patients that had difficulty communicating in English.

However:

- The service catered for individual patients' dietary requirements in a way that respected their religious and cultural needs.

Are services well-led?

Inadequate

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

- The provider did not have any visions or values.
- There was a lack of leadership within the service and staff did not feel supported by the senior management team.
- Senior managers did not maintain an oversight of staff mandatory training compliance.
- Staff did not have access to regular or effective supervision or an appraisal of their work performance.
- The service did not have effective systems and processes in place to ensure that patients were kept safe. This included a lack of effective medicines management practices, reporting and learning from incidents and compliance with the Mental Health Act and the Code of Practice.
- The service did not use key performance indicators to gauge the performance of the team.
- The service or provider did not maintain a risk register or other system to capture significant risks within the service.
- Staff were not provided with opportunities to provide their input into the running of the service.
- Staff morale within the service was low. Although staff displayed genuine enthusiasm for working with their patient group, they did not feel supported or empowered to do their job effectively. Training opportunities to facilitate staff development were limited.

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.

Staff at Ash House received no formal training in the Mental Health Act.

Mental Health Act documentation was poorly maintained. Patients detained under the Mental Health Act did not have copies of their detention paperwork filed within their individual care records.

A Mental Health Act review on 8 November 2016 found no information anywhere at the service informing patients how to contact an independent mental health advocate. The Mental Health Act administrator had no prior experience of the role. The Mental Health Act administrator for the service was a social worker who had received two days training to hold the post. There was no support in place for the administrator. There were no viable systems in place to monitor the use of the Mental Health Act around section 132 rights, renewal and appeal against detention, section 17 leave or consent to treatment. There was no copy of the Mental Health Act Code of Practice in the building.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was included in the mandatory training for the service. The training matrix provided by the service showed that 60% of staff at the service had completed the training.

We saw evidence of assessment of mental capacity in four out of six care records reviewed on 3 November 2016. Where capacity was limited, there was evidence of recording and consideration by the Responsible Clinician.

We saw no evidence of best interest meetings for patients at the service.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate

Long stay/rehabilitation mental health wards for working age adults

Inadequate

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe and clean environment

The hospital had three wards that were based over three floors. Chaucer ward was based on the ground floor and could accommodate up to eight patients in single en suite bedrooms. Blake ward was based on the first floor and could accommodate up to eight patients in single en suite bedrooms but was not in use at the time of our inspection. Tennyson ward was based on the second floor and could accommodate up to eight patients in single en suite bedrooms.

The lighting throughout the location was controlled by a motion detection system, meaning that if there was no movement within an area within a specified period the lights would automatically go off. This system would no doubt ensure that electricity would not be wasted. However, the system was flawed in that staff on upper floors reported being unsettled when the lights in the corridors went off; they told us they were wary for their safety.

Patient bedroom doors were left unlocked, however in order to access a bedroom many patients had to ask staff to open corridor doors controlled by a key fob. One patient on the top floor, once in his bedroom, was separated from the rest of the unit by a fob-controlled door and could only get out if there was a staff member available to open the door. There was a nurse call system in place, so nurses could be summoned for assistance in each room.

On 3 November, the front door to the unit was locked and the key was held only by a manager or the nurse in charge, so if someone wanted to access or leave the building the nurse or manager had to let them out. Support staff did not have keys for the main front and back doors to the building, which were locked when not in use. Although there were alternative fire exits, staff and patients would have to go back into the building to access them, potentially delaying their escape in the event of a fire.

When we went back to the unit on 15 November 2016 for further checks, keys to the front door had been provided to all active staff members on duty. We noted the fence around the garden of the location had a locked gate built in, but support staff were not given the combination to the lock, so in an evacuation situation they would have to wait for management to open the gate. On the day of the inspection, the nurse in charge did not know the combination to the gate.

We found blind spots throughout the three wards that were not adequately mitigated to reduce the risk to staff and patients. For example, the service did not use mirrors to allow for staff observation of patients located in blind spots within the building. The number of doors on corridors meant visibility was limited.

Staffing presence over the three wards was not consistent to ensure that patients were being adequately monitored

to ensure their safety. During our inspection on 3 November 2016, we observed that one support worker was left alone on one ward to support three patients for one hour.

Some key rooms within the building were not identified with clear signage (such as bathrooms, kitchens, clinics and nursing stations). This would make it difficult for new staff, including bank and agency workers, to navigate the building.

Ligature risks had been considered when the unit was built. A ligature point is something a person intent on self-harm may use to strangle themselves. There were three bedrooms on Tennyson ward with anti-ligature fittings. We were told these rooms would be used for patients assessed as being at risk of self-harm. They were not in use at the time of our inspection as none of the patients had been assessed as being at risk of self-harm.

There was no environmental ligature risk assessment or audit in place for the rest of the building. We would not necessarily expect a rehabilitation service to remove all ligature points, as patients will be preparing for discharge to the community. However, it is important that ligature points are identified to staff so that they can be considered as part of individual risk assessments. However, patients were not able to access any room other than their own bedroom without staff approval and assistance. .

On 3 November, there were no telephones in the ward offices, and only one telephone in the ward area that could connect to an outside line. Staff carried radios rather than personal alarms, and there were no panic buttons in the rooms or corridors. This increased the risk of staff not being able to respond quickly and/or call for external help in an emergency. On 15 November additional telephone handsets had been purchased (although all still used the same line, which meant that more than one member of staff could not dial out at the same time). There was still no personal alarm system. We were told that each floor had an emergency mobile phone, but we saw no evidence of this.

At the time of the inspection, the service only had male patients, so facilities provided were not measured against current Department of Health guidance regarding mixed-sex accommodation.

There were no local infection control guidance or audits in place to assess, prevent, detect and control the spread of infection. Managers and staff told us that the building (including clinic rooms) was being cleaned by support staff, who had not had specific training. Staff training records did not identify that they had received any training to clean the building, including clinical areas, effectively. The service could not produce any cleaning schedules or rotas to demonstrate that the building was being regularly cleaned and by whom.

All three floors had a separate clinic room. The clinic room on Chaucer ward did not have a clinical wash hand-basin. The Department of Health Health Building Note 00-09 paragraph 3.41 states that 'hand-hygiene facilities should be readily available in all clinical areas.' This was a concern because nursing staff dispensed medication within the clinic room and hand hygiene was paramount. This increased the risk of cross-contamination and infection. In Tennyson ward's clinic room, we saw the nurse dispensing medication using a non-disposable cup to assist swallowing medication for a patient, the cup being quickly rinsed under a tap before being refilled. The cup was not adequately cleaned, nor were disposable cups available. We also found a syringe barrel (no needle) that had been used to dispense medication from a bottle had been left on top of the medication trolley. The barrel was covered in a sticky substance and was stuck to the top of the trolley.

Both active clinic rooms were equipped with an electronic baseline physical observation machine and thermometer. Both clinic rooms had fridges to store medications that required it. First aid bags were available in both clinic rooms. Ligature cutters were kept in the locked clinic room, an area to which only the nurse in charge held the key. This meant that ligature cutters were only accessible to the nurse in charge.

On 3 November, only Chaucer ward's clinic room had a defibrillator machine and an oxygen cylinder was located in the entry hall to the building. There was no other emergency or resuscitation equipment available in the building. We raised concerns that the oxygen cylinder was heavy and would be difficult to transport upstairs quickly if required in an emergency. The service had recently recorded an incident whereby a patient on the second floor needed oxygen, but there were delays in using it because it was located on a different floor. Staff we spoke to on the day of inspection did not know the location of emergency equipment within the building. There were no signs on the doors to direct staff to where emergency equipment was stored.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

On 3 November, we found that the service did not provide new staff with an induction to the building to help orientate them to their surroundings; this included no orientation to where resuscitation and emergency equipment was kept. During our return visit to the service on the 15 November 2016, we found that senior management had introduced an induction information pack for all staff. We checked and found that staff on duty knew the location of the emergency equipment, including the additional items that had been sourced since our last inspection on 3 November 2016. This included a new defibrillator, electrocardiogram machine (not in use, as there had been no training at that time) and oxygen machine for Tennyson ward, as well as a suction machine (not in use, as there had been no training at that time). A new defibrillator sign showing that a defibrillator was now available on both ground and second floors had been placed by the main door to the building.

A legionella risk assessment had been completed in February 2016. We saw evidence that room water temperatures were being monitored in accordance with national guidelines.

We checked and found that staff recorded clinic fridge temperatures daily to ensure they were within optimum range. However, clinic rooms were very small and room temperature recordings for that day were in excess of 26 degrees on both Chaucer ward and Tennyson ward. This was a risk because room temperatures in excess of 25 degrees Celsius can affect the shelf life of some stored medication. We found that between 1 September 2016 and 14 November 2016, staff recorded clinic room temperatures to be in excess of 25 degrees Celsius in all cases except seven. The temperature recording log clearly identified that staff should report temperatures recorded in excess of 25 degrees Celsius; however, this had not happened. This meant that staff could not be sure that medication was safe to be administered to patients.

There were no controlled drugs kept at the service. Medication was blister packed for each patient and was colour coordinated for morning, afternoon and evening medication.

All ward areas were clean and tidy. Furniture was new and well maintained. The kitchen was clean and fridge temperatures were recorded and noted to be within the acceptable range. However, there was no cook at the weekends, and staff were required to cook for the patients. There was a separate fridge for a patient who requested halal food.

Safe staffing

Qualified staff comprised three registered nurses, an occupational therapist, and, we were told by the registered manager, 35 unqualified support workers including bank staff and part time workers. However, we could only find evidence of 20 support workers on the personnel checklist. There was a vacancy for another qualified nurse. The unit worked with one qualified member of staff to cover the day shift and one qualified member of staff for the night shift, to cover both floors in use at the time of the inspection. The registered manager stated that agency nurses were regularly used, and that the same staff were normally requested to work on the unit. We were told that should extra staff be required then the provider had an 'internal bank' of staff that would be used.

On arrival on the unit on 3 November 2016, we asked the nurse in charge for information relating to the patients regarding risk. The nurse could give no information regarding risk or Mental Health Act status. The handover of patient details had not been complete.

We were told by the nurse on duty on the day of inspection that they tried to take part in one to one interventions with patients, but it was difficult being the only trained member of staff on duty. Support workers stated that they would do one to one interventions if there were enough staff on duty. Checks on care records showed that one to one activities, if happening, were not being recorded consistently.

We were told that leave for patients was sometimes cancelled, but normally there were enough staff to cover, and if necessary, the occupational therapist would assist.

Mandatory training figures supplied by the service showed that every member of staff had an induction, however, there were no dates to show when the induction took place. Other mandatory training included basic first aid (60% trained), basic life support (55% trained), safeguarding adults and children (85% trained), infection control (80% trained), food safety (90% trained), and Equality and diversity (85% trained). The training was to be

renewed every year. The number of staff on the mandatory training figures (20 staff) differed from the staffing number given by the registered manager (35 staff), so the figures are not reliable.

The Responsible Clinician was asked about medical cover out of hours for the service. We were told that on call cover was not included in his contract. If there was an emergency, the patient would be taken to the accident and emergency department. There was no indication as to actions taken in the event of a psychiatric emergency.

Assessing and managing risk to patients and staff

We reviewed six patient risk assessments on 3 November. The service used their own risk assessment tool, which included health, environmental, behavioural and personal risks. We found that they did not accurately reflect or identify patient risks to themselves and others. Staff were not fully aware of the nature of risks. For example, one patient had assaulted a member of staff in a previous placement. This had not been recorded in his risk assessment or in his management plan. Three of the four staff we spoke to on 3 November, including the nurse in charge, did not know that this patient might pose any risk towards them or others.

The other risk assessments did cover more of the relevant areas but lacked detail. Staff were completing forms before and after patients' section 17 leave, but these also lacked relevant detail – there was no risk assessment completed immediately before the leave, and no record of how the leave went.

On 15 November, we reviewed five patients' individual risk assessments. All included a full history and clear management plan. A new section 17 leave form for staff had been introduced, which covered risk and other relevant information. We saw that this form had been completed for a patient going on leave on 14 November. We also saw that two patients identified as being at risk of choking had clear risk management plans in place, and that the provider was working with commissioners to access speech and language therapy assessments.

When asked if there was a policy on observations for the unit, the registered manager replied that he was not sure. Staff were given 'pat-down' training in relation to the searching of patients; this was done in-house. The registered manager said that there would only be such searches conducted if the staff had 'intelligence' suggesting it was necessary.

We were told by the registered manager that there was a policy regarding managing violence and aggression from patients. We were told that at that time, there had only been breakaway training, and not all staff had been trained in 'team teach '. The mandatory training matrix showed that 11 out of 20 staff on the matrix had received this training, 55% of the staff on the matrix. The most recent training had taken place in April 2016, showing that more recent staff had yet to take the training. The registered manager stated that restraint would be limited to a maximum of seated restraint; patients would not be taken to the floor. The registered manager stated that all staff had restraint training, but the training matrix provided did not show any restraint training registered.

There was a safeguarding policy in place at the unit. However, we were told of a patient absconding several weeks prior to inspection that had not been reported to the CQC or raised as a safeguarding concern. We saw from an incident form that staff had raised concerns internally about a patient trying to financially exploit another patient; this information was not included in either of their risk assessment or management plans and there was no evidence of a safeguarding referral having been made. Staff told us that they made safeguarding referrals over the telephone and did not document them on patient records.

The registered manager stated that there was a policy for rapid tranquilisation, but that rapid tranquilisation had not been used. However, the nominated individual stated that the service would not accept patients who may require rapid tranquilisation, and if this was necessary, the patient would be discharged from the service. Staff had not received training in immediate life support, but they were awaiting dates for the training to begin.

Medication was provided by a local pharmacy. The pharmacy did not carry out any medication audits. There was a medication policy, this stated audits were to be carried out by the senior management team. At the time of the inspection, no medication audits had been carried out.

Best practice was not being followed in the prescribing of medication. At the time of the inspection, we found that a patient had been admitted to the unit on 28 October 2016

Long stay/rehabilitation mental health wards for working age adults

Inadequate

who was prescribed clozapine. Nurses continued to administer clozapine without the knowledge of the Responsible Clinician (or any doctor). This included initiating a new prescription chart. There were no arrangements in place for physical health monitoring for the patient, and no liaison with the clozapine patient monitoring service. Clozapine use requires strict monitoring due to possible side effects and negative impact on a patient.

There was a comprehensive list of prohibited items on a notice near the front door to the unit, aimed at visitors to the unit. We found evidence of blanket restrictions that were not balanced against individual needs, such as no cigarette lighters for anyone, and access to the garden was via a locked door, requiring staff to allow access. The crockery used by patients consisted of tin plates and cups, painted to look like pottery.

On 3 November, we found that pre-employment checks had not been carried out for some staff. The Responsible Clinician had no disclosure and barring service check and no references taken up. A support worker file had no record of a photographic identity check being completed or record of disclosure and barring service check outcome. However, on 15 November all staff files contained the appropriate pre-employment checks. This included completed disclosure and barring service checks for the relevant staff who did not have them on 3 November 2016.

Track record on safety

CQC have been notified of one serious incident since the unit opened. On 25 October, a patient choked on food and was taken to hospital by paramedics. He sadly died of his injuries on 11 November. A police investigation into this incident is on going. We saw on 15 November that the service had taken measures to improve the quality of the risk assessment and management plans for two other patients identified as being at risk of choking.

Reporting incidents and learning from when things go wrong

Staff told us that they did not always know who to report their concerns to, as there were several different managers.

We were told that patients were informed when things went wrong, in an informal manner, but could not find any evidence of this taking place.

A staff member said she was only aware of one patient incident, this referred to the choking incident in October 2016 resulting in the patient being taken to hospital. We were told by the head of service that there had been a debriefing for staff, but we could find no evidence of this.

Ash House's incident reports were collated by the head of service. We could not find evidence of actions being implemented, or lessons learned disseminated, from incidents. For example, on 3 October 2016 a patient fell. The incident form documents that staff 'heard a thud' and found him on the ground. The patient should have been on one to one observation at the time. There was no record of this having been addressed with staff, or of measures being put in place to prevent this happening again. During the inspection on 3 November 2016, we learned that a patient had absconded prior to our inspection, but there was no evidence of feedback given to staff regarding the incident.

Duty of Candour

The registered manager said that he thought there was a policy on this, but was not aware of it. We saw no evidence that duty of candour had been applied. Staff we spoke to said that they had not heard of duty of candour.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

We viewed six care records on 3 November and five care records on 15 November.

A member of the management team, usually the head of service, completed an assessment with each patient prior to admission. This assessment included a summary of relevant history and current difficulties. It was based on interviews with staff from the hospital the patient was in at the time of referral and an interview with the patient.

Patients did not receive a detailed, comprehensive assessment of their mental or physical health following

admission. This meant that the service's understanding of patient needs was based on the pre-admission assessment and did not include contributions from other members of the multidisciplinary team.

Care plans consisted of two documents, 'this is me' and a clinical management plan. Five of the six records viewed on 3 November contained a 'this is me', and all contained a clinical management plan. 'This is me' was written from the perspective of the patient and included information on religious beliefs, hobbies/interests, personal care, hearing and vision, communication, mobility, mental state and cognition, pain, eating and drinking, medical conditions and allergies. There was no evidence of patient input into the clinical management plan. It included Mental Health Act status, medication and staffing ratio; and a list of needs, required actions or interventions, and expected outcomes. All care plans included information that was individual to each patient.

None of the care plans were recovery-focused, and none included goals that had been set by patients. Instead, care plans focused on patients' immediate needs (for example money management, contact with family, and leave from the ward). 'Required actions or interventions' were strategies for staff to use. For example, a patient who was known to experience anxiety was identified as responding well to reassurance and distraction. Desired outcomes were also defined by staff, for example 'to maintain safety', 'to ensure when possible that [the patient] understands his rights during his detention under the Mental Health Act'.

There was evidence of some physical health monitoring; for example, a patient who was at risk of developing pressure ulcers had a Waterlow risk assessment tool completed. There was a service level agreement with a local GP service to provide physical health care for patients; however, patients did not receive a physical health assessment on admission. The Responsible Clinician said he did no physical assessment, nor had he seen any documentation.

Current patient care records were stored on a desk in the staff office. The staff office was locked with a keypad and therefore not accessible to patients or others who did not have authority to see the records. However, we witnessed one patient being allowed into the office to get medication from a clinic room, which meant that he could have seen records belonging to other patients. Managers assured us that it was against policy to allow patients into offices or clinic rooms, and that they would address this incident with staff.

Information needed to deliver care was not available to staff when they needed it. Care records only included the most recent risk assessments, care plans, nursing notes and observation charts. Historic information (for example letters, risk assessments and care plans from previous hospitals or placements) was stored in a locked manager's office. None of the records included any Mental Health Act detention paperwork.

Records were stored on paper. Files were kept locked in a nursing station.

Best practice in treatment and care

We spoke with the pharmacy that provided Ash House patients with medication. The medication was blister packed and colour coded, and provided with a medication administration record sheet for each patient. The records sheet allowed the Responsible Clinician to add medications if deemed necessary. The record sheet was a 'standard issue', meeting the requirements of medication management under the National Institute for Health and Care Excellence guidance. However, we noted that one of the record sheets for a particular patient had not been issued with a date of birth in the relevant recording space. Medication charts did not have relevant Mental Health Act documentation attached. When we re-visited the location on 15 November 2016, the service had arranged new medication administration recording charts that had been created by a chief pharmacist's committee.

According to the Royal College of Psychiatrists (Enabling recovery for people with complex mental health needs: A template for rehabilitation services, 2009), the main function of a rehabilitation service is to provide specialist treatment in a suitable setting that helps patients gain or regain the skills and confidence to achieve their own goals. Ash House did not provide any psychological therapies, specialist interventions or reflective practice groups. Support workers assisted patients with budgeting, shopping and cooking, but were not getting any guidance from senior members of staff to help them to develop patient independence.

The head of service described the treatment provided by the unit as a 'formal neurorehabilitation programme' based

on a model of neurorehabilitation known as the Giles-Clarke model. He had developed this approach from his own and others' research and experience. He explained that he promoted positive relationships between staff and patients; encouraging staff to look for and build on patients' strengths rather than focusing on behaviours that challenged. This is similar to the concept of 'therapeutic optimism' described as a major aspect of the purpose of rehabilitation services by the Royal College of Psychiatrists. The head of service spoke to individual staff to share his assessment and give advice on positive relationships. Staff told us that they found this helpful. However, these discussions were not documented and did not happen with all staff, just those that were on shift when patients were first admitted.

There was a service level agreement in place with a general practitioner, who visited the ward weekly to look after patients' physical health needs. We saw no evidence in client care records that this was happening.

There was one patient on the ward with cognitive impairment. There was evidence on his care record that his nutrition and hydration needs were being monitored and met.

Staff did not use any recognised rating scales to assess and record severity and outcomes. The service monitored their effectiveness by collecting information about the number of incidents involving each patient, and looking for patterns over a period. This did not show whether patients were making any progress towards a successful community discharge.

None of the clinical staff participated in clinical audit. The registered manager had completed one general audit in September 2016.

Skilled staff to deliver care

The service employed a range of mental health disciplines, including psychiatry, occupational therapy, social work, nursing and support work. However, there was no clinical psychologist and the specialist rehabilitation input available from psychiatry, occupational therapy and social work was limited. The consultant psychiatrist was only on site for two evenings a week (around six hours in total) and therefore could not provide detailed mental and physical health assessment, care planning and leadership. The occupational therapist had taken an informal management role, and did not facilitate individual or group activities in the unit or in the community. The social worker was employed as a Mental Health Act administrator, and gave no advice on access to accommodation, money matters or other legal issues.

The head of service had a doctoral-level background in research in psychology, and had done some clinical work in the past. However, he was not a registered practitioner psychologist and did not provide any direct therapeutic input to patients.

Staff had not received an appropriate induction for their role. None of the staff on duty on the first day of our inspection could tell us where the emergency equipment was located. One support worker, who had been working at the service for two weeks, had had no induction or training. This support worker had been escorting patients on section 17 leave. On 3 November, the same support worker was left alone on one of the wards for an hour with three patients.

The registered manager told us that there was no leadership training for managers. A supervision matrix provided after the inspection showed that there was planning for appraisals; the service had not been open for a year at the time of inspection, so appraisals had not been started. Supervision was seen to be happening, but not regularly. Some staff had been more than five months without any supervision.

Nurses and support workers did not have access to team meetings. Minutes showed that only the clinical lead nurse, the occupational therapist and the senior management team attended. This meant that information about patients and about the running of the service was not being shared effectively with all staff.

The head of service had attended external conferences within the past year. He had also provided training on acquired brain injury to the rest of the staff, which may have helped them understand some of their patients' needs. There was no other evidence of staff having access to specialist training.

The service took steps to address poor performance when we found problems on the day of our inspection. There were no records of any poor performance prior to our inspection.

Multidisciplinary and inter-agency team work

Multidisciplinary meetings to discuss individual patients took place twice a week (with each patient being discussed

once a week). Notes in the patient records indicated that multidisciplinary meetings were attended by the Responsible Clinician, occupational therapist and head of service. There was not always a nurse present and there was no evidence that any other professional (for example a community team care coordinator) had attended. Multidisciplinary meetings took place in the evenings, which made it difficult for some staff to attend. Nurses could not leave the wards when there were no other nurses available to cover. This system was not effective. Important information about patients' medication had not been communicated to the Responsible Clinician by nurses, and to nurses by the Responsible Clinician. For example, one patient had had clozapine (an antipsychotic medication which increases risks to physical health) administered by nurses for six days without the Responsible Clinician's knowledge. The lack of nursing staff present during multidisciplinary meetings meant the information from the Responsible Clinician was not adequately being passed on to nursing staff.

Handovers between shifts were not effective. When we arrived on site on 3 November, the nurse in charge could not tell us the Mental Health Act status of any of the patients. We reviewed six handover records, which lacked detail about patients' presentations and risks. However, on 15 November a new handover prompt sheet had been implemented. On 15 November, the nurse in charge was able to give us a detailed account of patients' Mental Health Act status, risks and any issues that needed to be acted upon during that shift.

We did not see any evidence of routine liaison with teams outside the service in patient care records. However, the nursing notes in the care records only covered the preceding three weeks. Staff had made a safeguarding referral to the local authority, and informed commissioners and relevant care coordinators, following a recent serious incident.

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

Staff at Ash House received no formal training in the Mental Health Act. The support staff we spoke to lacked a basic understanding of the principles of the Mental Health Act.

Mental Health Act documentation was poorly maintained. Patients detained under the Mental Health Act did not have copies of their detention paperwork filed within their individual care records.

We found that two patients who were deemed not to have capacity to understand their rights had not had their rights revisited nor had an advocate been contacted. Two patients who had been detained in August 2016 and October 2016 had no evidence to show they had ever been read their rights. There was no evidence to show that advocacy was being accessed or offered to the patients at the service. A Mental Health Act review on 8 November 2016 found no information anywhere at the service informing patients how to contact an independent mental health advocate. The registered manager stated that this was the responsibility of the Mental Health Act administrator. The registered manager stated access to advocacy was "very limited", as it was difficult to contact them.

The Mental Health Act review found that all patients had valid detention paperwork. However, issues regarding consent to treatment were found. One patient was being treated under section 62 (emergency treatment) of the Mental Health Act since October 2016, but there was no record with the Care Quality Commission that a second doctor's opinion had been submitted. The completion of three T2 documents regarding consent to treatment showed that the Responsible Clinician had not assessed the patient's capacity to consent to treatment at the most recent authorisation. Patients and staff confirmed that copies of section 17 leave forms were not being offered to patients. There was no documentation on records of how the leave went for the patient.

The Mental Health Act administrator had no prior experience of the role. The Mental Health Act administrator for the service was a social worker who had received two days training to hold the post. There was no support in place for the administrator. There were no viable systems in place to monitor the use of the Mental Health Act around section 132 rights, renewal and appeal against detention, section 17 leave or consent to treatment. There was no copy of the Mental Health Act Code of Practice in the building; the administrator used an electronic version on his computer, but this was not available in the ward area.

Good practice in applying the Mental Capacity Act

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Mental Capacity Act training was included in the mandatory training for the service. The training matrix provided by the service showed that 60% of staff had completed the training. Staff we spoke to did have knowledge of the principles and what they meant.

We saw evidence of assessment of mental capacity in four out of six care records reviewed on 3 November 2016. Where capacity was limited, there was evidence of recording and consideration by the Responsible Clinician.

We saw no evidence of best interest meetings for patients at the service. There had been one patient detained at the service under Deprivation of Liberty Safeguards, but their detention status had changed to section 3 of the Mental Health Act. The registered manager stated Deprivation of Liberty Safeguard applications were made through the Mental Health Act administrator, or by the lead nurse.

We were not able to discern if there was a central point of contact if advice was required. There was nothing in place to audit adherence to the Mental Capacity Act.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Requires improvement

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Staff treated patients with dignity and respect.

We spoke to patients who told us that staff were caring and genuinely took an interest in the individual needs. A patient told us that staff always knocked on his bedroom door before entering the room. The patient said he could have personalised his bedroom if he wanted, but he chose not to.

A patient told us that the location was always clean, and that they had to clean their own bathroom. There was always a support worker on the second floor, where his bedroom was situated. However, the patient did not feel he was as involved in his care plan as he could have been.

We spoke with two carers of patients. They spoke highly of the service, stating that staff had a lot of patience; they could not thank the staff enough. One carer said they had regular meetings with staff, and they were kept informed of what was happening with their relative.

The involvement of people in the care they receive

Patients had a six-week settling-in period at the service after admission. The registered manager stated that the Responsible Clinician would discuss treatment options with the patient. There was no evidence found during the inspection or the Mental Health Act review that advocacy was encouraged or accessed at the service.

The service had no forum where patients or carers could provide input into how the service should be delivered; the Mental Health Act review of 8 November 2016 could find no evidence of any patient meetings held by the service.

There were no leaflets or noticeboards holding information regarding treatment or patient rights. Patients were not involved in decisions about the service, such as staff recruitment.

There was evidence of consideration of patient views in care planning; the service used a “This is Me” format that was person-centred. Four of the six care plans reviewed on 3 November 2016 showed that patient views had been considered, and were written from the perspective of the patient.

Multidisciplinary meetings were held outside of normal working hours, due to the limited availability of the Responsible Clinician. This did not take into account preferences of patients at the service, or availability of external staff such as care coordinators.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people’s needs? (for example, to feedback?)

Inadequate

Access and discharge

After referral, patients were assessed by the head of service. Commissioners were then approached if the patient was

accepted, to discuss funding. The service had not been in a situation where it was full at the time of inspection. The pathway allowed for up to a three-year residency at the location.

There were no admission criteria in place at the time of the inspection. Only 55% of staff at the service had received breakaway training and none had received training in restraint. The service accepted patients with violent/offending histories. There was a patient with Alzheimer's disease, and the training did not reflect the skills required to deal with this patient. Only three non-managerial staff had completed cardio pulmonary resuscitation training.

There was adequate space in the location to move a patient from one ward to another, should it be required. Discharges took place during working hours. At the time of the inspection, a patient was due for discharge the next day, and this happened as planned. There was no evidence that any discharge from the service had been delayed at the time of the inspection.

The facilities promote recovery, comfort, dignity and confidentiality

Patients could access their bedrooms during the day. However, the configuration of the location meant that staff had to use their key fobs to open corridor doors for some patients. This meant that a patient leaving a room could find they had to wait for a staff member to be available before they patient could leave their bedroom corridor. There were, however, nurse call buttons in each bedroom.

Mobile phone access was assessed for each patient on admission. At the time of the inspection, the registered manager told us that one patient had full access to their mobile phone, with two others allowed use in the evenings. Patients were allowed to personalise their bedrooms, if they chose to.

There was no free access to an outdoor space. Access to the garden area was through a door from the main ground floor lounge area, and this door was secured and required staff to open the door to go out and to come in. This meant that patients had to wait to be allowed into the garden area and wait for available staff to open the door to let them into the building.

There was poor provision of activities within the service, with a lack of structured activities to aid patient recovery and rehabilitation. Some patients had activity planners, but patients said they mostly just watched television or went to the local shops with staff.

Patients could make their own hot drinks during the day.

Meeting the needs of all people who use the service

There was an elevator in place, to assist in reaching all floors in the building, but this required access by staff. Toilets and bathrooms had equipment such as handrails to assist patients with limited mobility, as well as adapted baths.

There were no noticeboards with information noted in the service during the inspection. We saw no evidence of any information leaflets in any language. We were told that one patient had access to a translator during his Mental Health Act Tribunal; however, a translator was not available during his reviews with the Responsible Clinician.

There was one patient at the service during the inspection who required consideration of religious needs, and it was noted that the kitchen had a separate fridge for halal foods. We were told that the patient was given the opportunity to visit a local mosque, but he refused.

Listening to and learning from concerns and complaints

The registered manager told us that there was no complaint policy for the service. The registered manager stated that the Mental Health Act administrator told patients how to complain during their induction to the service. We were told that there had been no formal complaints to the service at the time of the inspection.

The registered manager stated that complaints were resolved informally, but if the patient wanted to make a formal complaint then they would be asked to write it down. There were no notices or leaflets anywhere in the service advising people how to make a complaint. Staff we spoke to did not know how complaints were recorded or made formally.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Inadequate

Vision and values

The registered manager stated that there was no set vision or values for the service, suggesting that the provider of the service had only recently come together as a group. There were no team objectives to guide the way forward for the service.

The registered manager knew who the senior managers at the provider were, and senior management had visited the service.

Good governance

We found poor governance systems at the service, and this had an effect on the overall safety and quality of the service for both staff and patients.

The governance lead for the service stated she did not know what a risk register was and showed a poor knowledge of the systems to be in place for the running of a mental health rehabilitation service. There was no provision of evidence to show how quality was captured and shared up and down within the service.

The governance lead admitted they had not spent much time in the service, as they were responsible for the whole of the provider. The governance lead admitted that they needed "to be here more".

The clinical lead nurse at the service was removed from the service to work at another site in Sunderland in the period between the visits on 3 November 2016 and 15 November 2016. This action was taken despite the lead nurse being the only full time nurse available: the service had to be run by five members of the senior management team, three of whom had no core professional qualification in mental health or social care, and four of whom had no experience of working within the Mental Health Act. The service relied on agency nurses during this period. The lack of knowledge about the service from these agency staff was reflected in the inspection.

Key performance indicators were not used by the service to measure or gauge performance. This meant that performance could not be gauged to monitor whether the service was providing a good service, or where improvements were needed to take the service forward.

When asked if there was any administrative support for staff at the service, the registered manager told us that the support staff was on maternity leave, but there was a temporary staff member with the team for seven weeks.

There was no system in place to escalate or disseminate information about risk up or down the wider organisation. None of the team meeting minutes showed evidence of discussion about governance, audit, Mental Health Act or risks at service level.

There was one audit done by the registered manager in September 2016, in which the aim of the audit was to gauge how to show that the service was operating within Care Quality Commission guidelines. The method used did not identify the problems we discovered during the inspection, and there was no indication that the findings were fed back to the service or implemented.

Mandatory training was poorly supervised, and supervision was poorly monitored and sporadic. Supervision was not considered in relation to the specific staff member and their needs.

The lack of auditing of medication management was evident, resulting in the administration and prescribing of clozaril to a patient by nursing staff, without the authority of the Responsible Clinician.

The Mental Health Act was not being administrated in a meaningful or efficient manner. There was no up to date copy of the Mental Health Act Code of Practice available to all staff.

The service had also failed to act on the information it collected about the clinic room temperature. Staff had checked the temperature in both rooms on most days in September, October and November 2016. On 63 of 69 occasions, the temperature exceeded 25°C. The audit form clearly stated that the room temperature should not exceed 25°C under normal weather conditions. There was no evidence of this being discussed with senior managers, or any action taken to resolve the issue.

Leadership, morale and staff engagement

Support staff told us that they did not know who to speak to when they had concerns. Support staff and non-managerial nursing staff were not invited to attend team meetings. There was no opportunity for them to

Long stay/rehabilitation mental health wards for working age adults

Inadequate

contribute towards the development of the service. We saw evidence in supervision notes that staff had expressed concerns about patient safety, but no action had been taken.

Staff morale was low. Although staff displayed genuine enthusiasm for working with their patient group, they did not feel supported or empowered to do their job effectively. Training opportunities to facilitate staff development were limited.

There was a lack of leadership within the service, shown by the lack of knowledge of senior management in relation to the running of a mental health rehabilitation service.

Commitment to quality improvement and innovation

The service did not participate in any national quality improvement programmes or research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures.

As the overall rating for this service was 'inadequate', the CQC are considering placing the service in 'Special Measures'. This will be reviewed and finalised in light of factual accuracy checks. If placed into 'Special Measures' the service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Full information about our regulatory response to the concerns we have described in this report will be added to a final version of this report we will publish in due course.

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: Patients did not receive a comprehensive, multidisciplinary assessment of needs and preferences for care and treatment. Care plans did not include any long-term, recovery-focused goals. There were no psychological or occupational therapy interventions available to patients. This was a breach of regulation 9(1) There was no access to independent mental health advocacy in place, nor patient forums allowing patients or carers to input into care and treatment. This was a breach of regulation 9(3) (c&d)

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 How the regulation was not being met: Sufficient numbers of suitably qualified competent, skilled and experienced staff were not employed by the provider. There were only three substantive nurses to cover all shifts, leading to a high reliance on agency staff. Some support staff had not received the appropriate training and supervision to carry out their role. This was a breach of regulation 18(1) and 18(2)

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Recruitment procedures were not effective in ensuring that persons employed were of good character. There were no references or disclosure and barring service checks in place for the Responsible Clinician and a support worker. This was a breach of regulation 19(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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: There were no notices, leaflets, or documentation anywhere in the service instructing patients how to make a formal complaint, nor was there an efficient system to record and deal with such complaints. This was a breach of regulation 16(2)

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:

This section is primarily information for the provider

Requirement notices

There was no effective system in place to ensure patients were kept safe, such as no medication management practice, nor learning from incidents.

This was a breach of regulation 17(2) (a)

The service did not maintain a risk register to monitor risks relating to the health, safety and welfare of patients.

This was a breach of regulation 17(2) (b).