Oak Tree Forest Limited

Ellern Mede Moorgate

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We undertook an inspection of Ellern Mede Moorgate due to concerns being raised with the Care Quality Commission about the service. This inspection was focused on the safe key question. During the review of the evidence from the inspection, a regulatory breach was identified in the well-led key question.

Following this inspection our rating of safe, well-led and the overall rating of this location went down. We rated it as requires improvement because:

- The service did not have enough registered nurses and nursing assistants to ensure that patients got the care and treatment they needed. Staff and patients reported concerns about staffing levels as it impacted on therapeutic work and activities being delivered to patients. Staff morale was impacted by the levels of restraint used and acuity of the service.
- Staff used high levels of restraint due to the complex needs of the children and young people. The recording of restraint was not always detailed and in line with the requirements. Staff reported that they did not always feel confident in the techniques of restraint that they were required to use when restraining specific patients.
- The service had a significant backlog of incidents that were awaiting review by the manager. It was not clear how managers were assured that these incidents had been managed appropriately. Managers had not been able to identify learning and themes from these incidents. Incidents on the reporting system were not always detailed or comprehensive.
- Issues were identified with the management of medication and the clinic room on Aztec ward. This included staff not being aware of what was in the controlled drugs cupboard and issues with accessing the cupboard on Aztec ward. There was some expired medication and the sharps bin had not been signed and dated when opened. There were also some gaps in fridge temperature recording and some missed signatures on one patient's medication chart.
- Issues identified during the inspection indicated that the service's governance processes were not always effective.

However:

- The ward environments were safe and clean. Staff assessed and managed risk well. They followed good practice with respect to safeguarding.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in care decisions.
- Managers were aware of issues within the service and were making plans or starting to take action to ensure that these were addressed in a timely manner. Managers were open and honest about the issues they had identified.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement. See the above summary for details.

Summary of findings

Contents

Summary of this inspection

Background to Ellern Mede Moorgate

Ellern Mede Moorgate is a hospital run by Oak Tree Forest Limited. It provides specialist eating disorder inpatient services for children and adolescents. The hospital was established in September 2019 and provides treatment for up to 12 patients, both male and female.

The hospital has two six-bed wards. Inca ward is for young people aged 8 to 18 and Aztec Ward is for young adults aged 18 to 25. It offers treatment to patients with complex eating disorders and can support patients who require nasogastric feeding. The hospital has an on-site school to provide patients with an education during their admission.

The service had a hospital manager who had been in post since the end of August 2022. At the time of the inspection, the hospital manager had not yet applied to be the registered manager.

The service did not have a nominated Controlled Drugs Accountable Officer (CDAO) at the time of the inspection. A previous registered manager was still recorded as the CDAO. That registered manager had left their position at the end of June 2022. The provider had not yet nominated a replacement CDAO. This was brought to the provider's attention following the inspection.

The service is registered by the CQC to provide the following registered activities:

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

The service had been inspected once previously in June 2021 where it was rated good overall and for all key questions.

We undertook this inspection of Ellern Mede Moorgate due to concerns being raised with the Care Quality Commission about the service. This inspection was focused on the safe key question. During the review of the evidence from the inspection, a regulatory breach was identified in the well-led key question. The effective, caring and responsive key questions were not inspected and so the ratings for those key questions remain the same.

What people who use the service say

We spoke with three patients on the day of the inspection along with one patient remotely via telephone. All patients reported feeling safe in the hospital but raised concerns about the staffing levels. Patients felt that staff were often very busy and in demand by certain patients with higher needs. Patients described that they felt there was a lack of therapeutic activities and interactions as a result of staff being in demand. Patients described staff as caring and responsive to their needs. The patients we spoke to gave mixed feedback about agency staff used on the wards; one patient felt that agency staff were knowledgeable whilst another patient believed that too many agency staff were used on the wards.

We also spoke with three family members and carers remotely. They spoke positively about staff within the service and raised no concerns about the safety of their loved ones. They reported that their loved ones were informed and involved in decisions about their care and treatment. Family members did note that there were difficulties with communication with the hospital and that the level of communication with relatives was not always good. Family members also noted a concern about the service ensuring an appropriate staff gender mix on the wards due to historic traumas for their loved ones.

Summary of this inspection

How we carried out this inspection

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

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the environment and observed how staff were caring for patients;
- spoke with the hospital manager;
- spoke with seven staff members;
- spoke with four patients who were using the service;
- spoke with three family members or carers of people who were using the service;
- looked at four care and treatment records of patients and six prescription charts;
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that staff are aware of their responsibilities and processes when managing medication, controlled drugs and the clinic rooms. (Regulation 12(2)).
- The service must ensure that incidents are reviewed in a timely and efficient manner. The provider must ensure that themes and learning are identified from these incidents. The provider must continue to monitor the effectiveness of the incident reporting system and to ensure that improvements continue to be made to it. (Regulation 17(1)(2)).
- The service must ensure that staffing levels are reviewed and that actions continue to be taken to ensure that the service has safe staffing levels that provide appropriate and therapeutic care and treatment to all patients. (Regulation 18(1)).
- The service must ensure that all staff are appropriately trained and confident when using restraint techniques. (Regulation 12(1)(2)).
- The service must ensure that the ligature audit is completed on a regular basis and that actions are taken to address any areas identified as a concern from these audits. The service must ensure that staff are aware of any changes or risks identified in the new ligature audit. (Regulation 12(2)).

Action the service SHOULD take to improve:

- The service should ensure that the banned items list is reviewed and that all staff are aware of what items are banned in the hospital.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Specialist eating disorder services

Safe	Requires Improvement
Well-led	Requires Improvement

Are Specialist eating disorder services safe?

Requires Improvement

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

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not always complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified.

The most recent ligature audit of the hospital had been completed the week prior to the inspection in September 2022. A copy of this ligature audit was therefore not available on the day of the inspection. The hospital manager had been given initial feedback from the independent contractors who undertook the audit. A recommendation from this audit related to the high number of patient belongings in their rooms and how the provider was managing associated risks with these. The service was due to implement an individual weekly bedroom audit to assist staff with managing these risks. We reviewed the previous ligature audit that had been completed in March 2021. This ligature audit indicated that remedial actions were required to be taken mostly around patient belongings. As a similar theme had been identified on the 2022 audit, it was not clear that appropriate actions had been taken in the 2021 audit, although a process was now due to be implemented.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. The wards had anti-ligature fixtures and fittings that reduced the risk of fixed ligatures within the hospital.

Staff could not observe children and young people in all parts of the wards. In order to mitigate risk, staff used regular observations in line with the individual risk assessments of patients. Mirrors were placed throughout the wards to assist staff with observations. Closed-circuit television was available in communal areas such as the corridors and lounges.

The wards provided mixed sex accommodation which complied with guidance. Ten of the 12 bedrooms were ensuite and the final two female bedrooms shared one bathroom. The hospital manager explained how adjustments were made to the wards to ensure that single gender spaces could be provided on both wards as and when required.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. Staff carried personal alarms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. The provider had a maintenance team that would respond to any issues as identified.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing.

Seclusion room

The location did not have a seclusion room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Emergency equipment was only stored in the Aztec ward clinic room on the ground floor. The provider had an emergency equipment risk assessment that documented how staff would be expected to respond if the equipment was required on the first-floor ward. The provider had implemented quarterly emergency drills to review staff practice. The drills also indicated where areas of improvement were required.

Staff had not always checked, maintained, and cleaned equipment. In the Aztec clinic room, a sharps bin had been opened but had not been signed and dated. There were also gaps in the recording of fridge temperatures with three dates not recorded in August, two dates in July and seven dates in June.

Safe staffing

The service did not have enough nursing staff, who knew the children and young people well to deliver the care they required, although the service had enough staff to keep patients safe. Staff had completed required mandatory training.

Nursing staff

Patients and staff reported that they did not feel there were enough staff within the service. Patients described feeling safe on the ward, but that staff were taken away from therapeutic work and activities to respond to care needs and high levels of restraint. Staff reported similar concerns that their therapeutic work was impacted by this.

The service had enough nursing and support staff to keep children and young people safe. The service was frequently using staffing levels above the planned levels due to the acuity of the service. Staff reported that, whilst the staffing levels were safe in the service, they were concerned about the impact on the quality of care that they could provide and felt that more staff were needed. In order to fulfil the required staffing numbers for the service the service was using high numbers of temporary staff who did not all know patients well.

The service used high rates of agency nurses. In the period of 1 June 2022 to 30 August 2022 the service used 1667 hours of agency nurses which equated to 33.9% of the rostered hours. There were no hours of bank nurses used during this period.

The service used high rates of agency nursing assistants. In the period of 1 June 2022 to 30 August 2022 the service used 27250.25 hours of agency nursing assistants which equated to 61.67% of the rostered hours. There were also 103.5 hours of bank nursing assistants used during this period.

Managers recognised the importance of using bank and agency staff that were familiar with the service although acknowledged that this was not always possible.

Requires Improvement

Specialist eating disorder services

Managers recognised that staffing levels had been a challenge and were concerned about how this had impacted on morale. The hospital manager was keen to improve staff morale and ensure that staff felt supported within the service.

The service had reducing vacancy rates. The service had recruited nurses and nursing assistants who were due to be starting work in the service, although still had some ongoing vacancies.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service had checklists and processes to support new staff in understanding the service and to ensure that they were appropriately inducted into the service.

The service had high turnover rates over the 12 months prior to the inspection. In the period of 1 September 2021 and 30 August 2022 there were 31 staff leavers. The new hospital manager had, on their appointment into the post, requested an analysis of data around staff leavers and their reasons for leaving. The hospital manager recognised that retaining staff was a priority for the service.

Managers supported staff who needed time off for ill health. Managers described how they managed and offered support to staff who were off due to ill health.

Levels of sickness had increased since the last inspection but were reported to be reducing. Between the 1 September 2021 and 30 August 2022, the service had an average sickness rate of 7.26%. Managers reported that sickness levels were lower than this average rate at the time of the inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service had undertaken a core staffing establishment review in 2021 that set out the staffing establishments for each ward. At the time of the inspection, the service had not completed a further review of the core staffing establishment levels.

The ward managers could adjust staffing levels according to the needs of the patients. Staffing levels within the service were continuously above the planned establishment levels, reflecting the high acuity of the service.

Staff and patients noted that due to some patient experiences and histories, female members of staff could be quite heavily in demand to respond to restraints or the care needs of specific patients. The hospital manager noted that the gender mix of staff on each ward was considered by the ward managers who would attempt to ensure this was appropriate.

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

Patients did not raise concerns that they had their escorted leave, or activities cancelled, although did comment on a lack of activities within the service and that staff were often too busy to facilitate therapeutic work.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers reported that the service always had access to a consultant, and they were available when required.

Requires Improvement

Specialist eating disorder services

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. At the time of the inspection, the overall training compliance figures for the service was 96%. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed four patient records. The risk assessments were present and up to date in the four records reviewed. Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, children and young people. Staff discussed each patient's risk and any changes at every handover and in the morning meetings. Staff were aware of the patients they were supporting and felt informed about any changes or issues they might need to be aware of.

Staff followed procedures to minimise risks where they could not easily observe children and young people. Staff used regular observations in line with patients' risk assessments to reduce risks and reviewed these observation levels regularly to reduce them when safe to do so.

Staff followed policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

The service was due to be reviewing the banned items list to ensure that it was appropriate and up to date. The hospital manager explained that the revised list would be displayed on the wards to ensure that staff and patients were aware of the restricted items.

Use of restrictive interventions

The provider used high levels of restrictive interventions which reflected the number of planned nasogastric feeds. On Inca ward, staff had used an average of 357 incidents of restraint per month in the six months prior to the inspection; this figure was lower on Aztec at an average of 159 incidents of restraint per month. The total number of restraints reported for both wards during this period was 3096. This data indicated that the level of restraint used remained similar to the levels used at the time of the previous inspection.

Staff raised concerns about the level of restraint used in the service and did not always feel confident when using restraint techniques. The service trained staff in Ellern Mede Restrictive Interventions Support Training (EMRIST). This was a bespoke evidence-based training programme of restrictive interventions focused on improving the experience of nasogastric feeding for children and young people. Staff explained that the restraint techniques taught did not feel

secure enough when used with specific patients. The service was working to ensure that all staff and new inductees were up to date with their restraint training, including holding a training course for regular agency staff. Managers had noted that some staff were not confident with the techniques used but felt that this was because they did not always understand how the holds could be applied in certain situations.

Due to the levels of restraint in the service, there was a concern that staff may be burnt out and that it was impacting on staff morale. Managers recognised this as an issue and were identifying ways in which staff morale could be improved.

Staff participated in the provider's restrictive interventions reduction programme. The provider had completed a restrictive practices audit in March 2022. The provider had identified areas of improvement within this audit that they were working towards addressing.

Staff made attempts to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. Patients completed a Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) with staff. This allowed patients to discuss their possible restraints and staff help them to develop their own suitable and patient preferred strategies to be used. The strategies identified within the PILRIMP were personalised and specific to the individual patient.

We reviewed a selection of incidents of restraint. The incident recording forms were not always fully completed and did not always contain detailed descriptions of the circumstances or if less restrictive interventions were attempted prior to escalation. Staff had recorded some additional information and context elsewhere in the patient records however, it was not clear how this information was brought together. Following the on-site inspection, the provider supplied examples of restraint where less restrictive practices were attempted prior to staff engaging in restraint and evidence of how the PILRIMP was utilised by staff.

Staff followed NICE guidance when using rapid tranquilisation. The service used lower levels of rapid tranquilisation with 17 incidents of rapid tranquilisation being used across the two wards in the six months prior to the inspection.

The hospital did not have a seclusion room. One of the patients in the service was under significant restrictions at the time of the inspection and was essentially in long-term segregation. The provider had initiated these restrictions to ensure that the patient could be kept safe in the service due to recent incidents and the risks to their physical health. The patient was being regularly reviewed and the provider was liaising with commissioners in respect of the patient.

At the time of the inspection, one young person was an informal patient in the service. The young person was aware of their rights as an informal patient and confirmed that staff supported them with this. The hospital manager noted that signs informing patients of their right to leave the wards were due to be created and displayed on the wards.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. The service's training compliance figures for safeguarding were high. Due to the hospital manager being new in post, they had not completed their required level four training in safeguarding; this was in the process of being organised with an external trainer.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. The service had a procedure that would be followed if children were visiting the service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Between the 1st January 2022 to 20th September 2022, the hospital had made 31 external safeguarding referrals; 17 to children's services and 14 to adult services. The service had made 78 internal referrals during that same time period. 35 relating to patient care, 38 relating to safeguarding and two in respect of police involvement.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely.

Medicines management

The service did not always use systems and processes effectively to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

On Aztec ward, staff stated that there were no patients prescribed controlled drugs. The controlled drugs book indicated that gabapentin tablets had been checked in the cupboard on two dates in August. There was no indication in the controlled drugs book that the tablets had been checked since August or removed from the controlled drugs cabinet. The staff member accompanying the member of the inspection team was not aware of the process to open the controlled drugs cabinet. We reviewed the cabinet later in the day which confirmed that the gabapentin tablets were still present. This was escalated to management to ensure that staff were aware of their responsibilities and processes. The provider supplied evidence following the inspection that actions had been taken to address this.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed six prescription charts. Staff had not signed for the administration of medication on one patient's chart four times across two days. No issues were identified with the other five charts reviewed. There were also some small amounts of medication and equipment that had expired in the Aztec clinic room.

Staff reviewed patient's medicines regularly and provided specific advice to patients about their medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Staff completed regular physical health checks and monitoring on patients.

Requires Improvement

Specialist eating disorder services

Track record on safety

Reporting incidents and learning from when things go wrong

The service had a backlog of incidents pending review on the incident reporting system. It was not clear how the provider was assured that these incidents had been managed appropriately. As these incidents had not been reviewed, no learning or themes had been identified from them. However, staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

The provider had an organisational incident reporting system that had been developed. Managers reported that changes were still being made to the system based on feedback and learning whilst the system was in use.

There were a significant number of incidents that were pending management review on the day of the inspection. The hospital manager had 342 incidents awaiting review on the system. The hospital manager explained how they planned to address this and ensure that learning and themes from these incidents were identified for each patient. Senior managers in the organisation queried incidents with key words of concern. It was, however, concerning that the provider did not have appropriate oversight of the incidents and any essential learning or themes that might have been identified from these, which may have helped prevent future incidents in the service.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported serious incidents clearly and in line with policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. The hospital had two incidents in the 12 months prior to the inspection that met the threshold for the duty of candour. Both incidents were relating to one of the patients in the service. Managers had followed the provider's duty of candour procedure and had apologised to the patient and their family; following this with a written apology.

Managers debriefed and supported staff after any serious incident. Staff reported that this was normally an informal debrief but that they felt supported by management.

The organisation produced a monthly lessons learnt bulletin highlighting a specific incident, practice and learning from across the organisation.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. We observed the minutes of a team debrief that had taken place in August 2022 to discuss and review a specific incident. This meeting reflected on the response of staff and considered any areas of learning or improvement. The service identified actions from this meeting to improve both the patient's care and treatment alongside the service as a whole.

Requires Improvement

Specialist eating disorder services

Are Specialist eating disorder services well-led?

Requires Improvement

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Issues identified during the inspection indicated that the service's governance processes were not always effective.

On the day of the inspection, the service had 342 incidents that were pending review on the provider's incident reporting system. Whilst senior managers in the organisation completed key word searches of incidents, it was not clear how the provider was assured that these incidents had been managed appropriately. Due to the number of incidents pending, it was also not clear how the provider had identified any learning or themes from the incidents. The hospital manager was aware of this issue and had an informal plan of how they were going to address this.

The incident reporting system itself had some limitations such as job titles not being included and some issues with the recording of incidents not always being detailed and effective. Managers confirmed that they continued to give feedback to the developers on how the system could be improved and that actions were continuously being taken to bring the system to their expected standard.

There were further issues identified during the inspection that the service's governance processes had not identified, including gaps in the recording of checks of the Aztec clinic room; the oversight of controlled drugs not being effectively managed; a theme from the previous year's ligature audit not being appropriately addressed and the banned items list had not been reviewed at the time of the inspection.

The hospital manager had only recently started in post, although had a background in the organisation and had previously worked at the hospital. They had identified areas that could be improved within the service and was making plans to ensure that these were addressed. Although a formal action plan had not been implemented at the time of the inspection, the hospital manager could explain actions that they planned to take to address the areas identified. Managers were open and honest about these issues and responded positively to feedback on areas that required improvement.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • The recording of restraint was not always detailed and in line with the requirements. Staff reported that they did not always feel confident in the techniques of restraint that they were required to use when restraining specific patients. • Issues were identified with the management of medication and the clinic room on Aztec ward. This included staff not being aware of what was in the controlled drugs cupboard and issues with accessing the cupboard on Aztec ward. There was some expired medication and the sharps bin had not been signed and dated when opened. There were also some gaps in fridge temperature recording and some missed signatures on one patient's medication chart.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service had a significant backlog of incidents that were awaiting review by the manager. It was not clear how managers were assured that these incidents had been managed appropriately. Managers had not been able to identify learning and themes from these incidents. Incidents on the reporting system were not always detailed or comprehensive. • Issues identified during the inspection indicated that the service's governance processes were not always effective. This included gaps in the recording of checks of the Aztec clinic room; the oversight of controlled

This section is primarily information for the provider

Requirement notices

drugs not being effectively managed; a theme from the previous year's ligature audit not being appropriately addressed and the banned items list had not been reviewed at the time of the inspection.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service did not have enough registered nurses and nursing assistants to ensure that patients got the care and treatment they needed. Staff and patients reported concerns about staffing levels as it impacted on therapeutic work and activities being delivered to patients. Staff morale was impacted by the levels of restraint used and acuity of the service.