Mundesley Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This service was placed in special measures in December 2016. Insufficient improvements have been made such that there remains a rating of inadequate for any core service, key question or overall. Therefore, we are taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Edward Baker
Chief Inspector of Hospitals

Overall summary

CQC first inspected Mundesley Hospital in September 2016. Following that inspection, we rated the service as inadequate. Due to our concerns, we issued the hospital with a warning notice and placed it into special measures. CQC carried out a focussed, unannounced inspection of the hospital in January 2017 to check on progress against the warning notice and to look at some additional concerns that were raised with CQC.

In June 2017, we carried out a further announced, comprehensive inspection to reassess the service six months after we decided to place it into special measures. During this inspection we reviewed progress against the warning notice and the requirement notices. Although we found that the service had addressed some of our previous concerns, we have once again rated Mundesley Hospital as inadequate. This is because:

- We identified a serious incident where staff did not report an incident of restraint through the hospital reporting system.
- This matter was also not reported to safeguarding. We could not be assured that staff were transparent in alerting the hospital's management or external bodies about incidents.
- We saw evidence of a culture where staff did not always respond to patients' needs. For instance, we saw several staff eating breakfast whilst a patient waited to enter the dining area. We saw several different staff ignore a patient who knocked at the office door.
- The hospital had an informal feel and staff spoke of a family environment. There was some evidence that the informality bordered on poor conduct, with some staff lacking a professional approach. Some patients complained of staff gossiping about each other in front of them.
- Some patients commented on the difference between the care they received during the day and the night. They reported that at night, staff were not as caring and were less approachable.
- Four patients reported that staff sometimes fell asleep on duty when they were meant to be observing the patient.
- We saw inconsistencies in documentation of enhanced observations on the recording sheets. This meant we could not be sure that the staff carried out observation entries in a timely manner. This also fuelled concern that observations may not have been carried out according to policy. Failure to carry out observations could result in harm to the patient. We raised this with senior managers following the second part of the inspection.
- We found one box of medication that staff had not labelled correctly. Staff had written the name of the medication on the box stating the tablet strength was 2.5mg. We checked the contents and the box held 5mg tablets. This may have resulted in an administration of

Summary of findings

medication error. This box had been in use for a period of time and this had not been identified through audit. We raised this concern with the provider immediately for investigation and action.

- We saw that staff requested all patients complete a permission form to carry out a body search regardless of their individual risk at admission and following leave from the hospital.This practice meant staff searched patients without considered reason of individual circumstance or risk. Following a serious incident the hospital advised the inspection team of a change of process to ensure only patients with known risk were searched following leave. Patient records did not clearly state if searches carried out were due to known risk. The provider continued to carry out body searches at admission.
- There was no access to any kind of psychology service. We did not see evidence of any other psychology support such as staff trained in DBT (dialectical behaviour therapy), art therapy or psycho-educational therapies.
- The provider failed to provide CQC with accurate pre inspection information about staffing. For example, the provider submitted information that there was a vacancy rate of just under 2% for registered nurses. During inspection we saw a vacancy rate of over 80%.
- During inspection the hospital provided figures of 90% compliance of supervision. Staff records we reviewed did not support this.
- There was a serious incident of self-harm on the ward. This incident was reported by front line staff. The detail within the verbal account provided during the inspection was misleading. We challenged the provider who acknowledged that incorrect information had been given.
- Areas of risk to patients were not being managed effectively by the organisation. For example, the provider had not proactively identified areas of poor practice identified throughout this report. Internal audit and management systems had not identified areas of poor practice and how the service could improve.

However:

- The hospital had addressed most of the concerns raised in the warning notice issued following the inspection in January 2017.
- Admission paperwork was completed, physical health needs were assessed, identified and plans were in place to address patients' needs.
- We saw evidence of contingency and crisis planning with most patients.
- Contemporaneous notes were in order, mostly legible and showed patient progress.
- We saw an excellent handover. The staff conducted it in a careful and considered manner, identified patient need and highlighted areas of risk while describing the management plan.
- Managers had introduced a system to ensure that staff reviewed incidents and learned lessons.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Inadequate 	We rated this service as inadequate.

Summary of findings

Contents

Inadequate

Mundesley Hospital

Acute wards for adults of working age and psychiatric intensive care units

Summary of this inspection

Background to Mundesley Hospital

Mundesley Hospital registered with the Care Quality Commission in December 2015 and admitted patients for the first time in February 2016. It is registered to carry out the following regulated activities:

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

Mundesley Hospital is a private mental health care facility located in the North Norfolk countryside. The hospital has 27 beds for adults who require assessment and treatment in an inpatient setting. Patients are either informal or detained under the Mental Health Act (1983).

The hospital provides acute inpatient care for patients requiring urgent and immediate treatment for their mental health condition.

There are six suites located over two floors.

On the ground floor, there are two adjoining inpatient suites, Middleton and Crome. Middleton can accommodate up to six patients and Crome up to five patients.

On the first floor, there are four in-patient suites. Thirtle, Stannard, Vincent and Bright can accommodate four patients each. Thirtle and Stannard are designated female in-patient suites. Vincent and Bright are for either male or female patients. During inspection, two suites were not in use.

A registered manager was in place at the location. The registered manager, Catherine Guelbert, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010. Catherine Guelbert is also the Chief Executive of Mundesley Hospital.

We followed up with an unannounced focussed inspection in January 2017. This inspection was not rated. We reviewed compliance with the warning notice and found that the warning notice requirements had not all been met. There was evidence of progress in some areas however we found further evidence of poor practice. A further warning notice was issued in February 2017 providing clear evidence of concerns.

Due to our concerns the hospital was issued with a warning notice and was placed in Special Measures.

Following our inspection in January 2017 we issued the provider with a number of requirement notices and another warning notice.

- The provider must ensure that all staff are up to date with Mental Health Act training.
- The provider must ensure that all qualified staff receive immediate life support training.
- The provider must ensure that all incidents are reported via their internal reporting process.
- The provider must ensure there are appropriate systems in place to learn from incidents and share that learning with all staff.
- The provider must ensure that staff monitor and record the physical health of patients who have received rapid tranquillisation.
- The provider must ensure that the escorting of patients around the building is based on a clinical assessment of individual risk.
- The provider must ensure that care plans are completed fully and are detailed, and based upon individual risk assessment. The risk assessments must be updated regularly, with clear management plans in place.
- The provider must ensure that physical health nursing assessments are completed and areas of need are addressed.
- The provider must ensure that contemporaneous notes are legible, detailed, in chronological order and reflect patient progress.
- The provider must ensure that all clinical audits have an action plan in place to address the quality of care and concerns identified.
- The provider must ensure that the Mental Health Act Code of Practice (2015) is adhered to in the respect of caring for patients in long-term segregation.

Summary of this inspection

- The provider must ensure patients are aware where CCTV is in operation.

Our inspection team

Team leader: Jane Crolley, Inspector

The team that inspected the service comprised two CQC inspectors, two inspection managers, a Mental Health Act reviewer, one specialist advisor who was a consultant psychiatrist and one specialist advisor who was a social worker.

Why we carried out this inspection

This was an announced, comprehensive inspection to reassess the service six months after we decided to place it into special measures. During this inspection we reviewed progress against the warning notice and the requirement notices.

How we carried out this inspection

To fully understand the progress made by the service we concentrated our inspection on the following domains:

- Is it Safe?
- Is it Effective?
- Is it Caring?
- Is it Responsive?
- Is it Well Led?

Before the inspection visit, we reviewed the warning notice and the action plan provided by the provider on how they planned to achieve compliance.

During the inspection visit the inspection team:

- visited all six suites at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 14 patients who were using the service
- spoke with one carer
- interviewed five senior managers plus the registered manager, the chief executive and one of the owners
- met with 16 other staff members; including doctors, nurses, the occupational therapist, pharmacist and healthcare assistants
- reviewed 14 comment cards from staff, patients and carers
- examined 14 clinical records of patients and carried out a specific check of the medication management
- reviewed 13 care plans
- looked at a range of policies, procedures and other documents relating to the running of the service
- attended a handover
- examined minutes and other supporting documents relating to the governance of the hospital
- conducted an unannounced night visit
- Reviewed in detail11 staff records.

What people who use the service say

During the announced and unannounced inspections we spoke with 14 patients.

Eight patients we spoke with said that they liked the hospital and that there were plenty of staff.

Summary of this inspection

Patients enjoyed the food and were happy with access to food and drink.

Five patients raised concern that staff did not always respond in a timely manner when they requested something.

Two patients said they witnessed staff bickering and gossiping in front of other patients.

Four patients commented on the difference between the care they received during the day and the night time care. They reported that at night, staff were not as caring and were less approachable.

Three patients said that staff did not always knock before entering their bedrooms.

Four patients reported that staff fell asleep on duty.

A carer felt that their relative was safe and that staff were welcoming during the admission process.

Patients said they were involved with their care plan as much as they wanted to be. Activities were available and that they were occupied.

Patients knew how to complain and felt listened to when they did.

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:

- During the inspection period, a serious incident took place which staff did not record accurately within the clinical notes as a restraint or safeguarding incident. These were allegations of the inappropriate manhandling of a patient. Staff did not report the incident to senior managers or through the incident reporting system. Following a complaint, the senior managers took appropriate action to report and investigate. There was a concern that staff used restraint and did not report its use. This meant we could not be assured that patients were fully protected from abuse or improper treatment.
- Staff had not reported all incidents at the hospital in line with the provider's policy. We knew of one serious incident that staff had not reported at the time and one that was reported with inaccurate detail.
- There were inconsistencies in documentation of enhanced observations on the recording sheets. We could not be assured that staff carried out observation entries in a timely manner.
- Agency staff formed a large part of the staff team. At the time of the inspection the provider was regularly using 63% agency staff.
- One staff member had failed to carry out observations for one patient during the night. The patient should have been checked hourly. This raised concern that enhanced observations may not have been carried out according to policy.
- The environmental risk assessment identified ligature points within the hospital. Where a patient had a risk of self-harm their risk assessment and care plan did not demonstrate how to manage these environmental risks.
- There was not an environmental risk assessment for the outdoor areas and there was not a clear plan on how staff managed these risks.
- The nursing assessment undertaken at admission did not include a falls screen and we did not see evidence of routine completion of falls screens. Following inspection, the provider told us a more comprehensive assessment had been put in place.
- We found one box of medication that staff had not labelled correctly. Staff had written the name of the medication on the box stating the tablet strength was 2.5mg. We checked the contents and the box held 5mg tablets. This may have resulted

Summary of this inspection

in an administration of medication error. This box was in use and the error had not been identified through audit. We raised this concern with the provider immediately for correction and investigation.

- The sharps bin was overfull. Another sharps bin which was also in use had not been labelled. We raised this with the registered nurse in the clinic room. When we went back on 19 June 2017 the sharps bin was correctly labelled but again was overfull.
- We found some blanket restrictions at the hospital. These included patients being unable to leave the hospital at will.
- Staff requested all patients to complete a permission form to carry out a body search. This practice meant staff searched patients without consideration of individual circumstance or risk.Prior to our inspection there was a serious incident relating to this practice that significantly compromised a patient's dignity during a search procedure. Following this incident, the provider acknowledged the error and reviewed the practice with a view to making changes. The hospital had not fully implemented the changes at the time of inspection. The provider continued to carry out body searches at admission.

However:

- Staff identified most patient risks on admission and staff reviewed them regularly. These risks were reflected in the care plan with guidance on how to support the patient in managing that risk.
- Risk assessments were undertaken prior to patients going on leave.
- We saw flexibility regarding staffing. Staff knew the process for escalating requests in response to increased clinical need and we saw that managers usually ensured sufficient staff were in place to meet the extra demands.
- Managers had introduced a system to ensure that staff reviewed incidents and learned lessons.Senior managers had developed a bulletin with plans to produce this weekly for staff. We saw evidence of direct learning from an incident.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There was no access to any kind of psychology service. We did not see evidence of any other psychology support such as staff trained in DBT (dialectical behaviour therapy), art therapy or psycho-educational therapies.
- Figures provided by the hospital showed compliance with supervision at 90%. From the HR records reviewed, we did not see evidence that supported these figures.

Summary of this inspection

- Staff did not repeat the reading of people's rights under the Mental Health Act for several days when patients initially did not understand these. This meant that patients, particularly those on short-term sections, had less time to appeal against their detention.
- Staff had not undertaken decision-specific assessments when these were indicated. For example, staff assessed a patient not to have mental capacity to consent to treatment but the patient had signed the consent to searching on the same day, without an assessment of their capacity to make this decision.
- Patients who lacked capacity and were detained under the Mental Health Act, were not automatically referred to an independent mental health advocate.
- Staff completed the malnutrition universal screening tool (MUST) in most cases but there were some gaps. Four of the 10 admission records we reviewed were incomplete, wrongly completed or not completed. This meant there was a risk that staff did not address the nutritional needs of all patients.

However:

- Following admission, staff undertook a comprehensive assessment of patients, usually within four hours of admission and always within 24 hours.
- Physical health examinations were undertaken and actions from these were recorded in the assessment and care plans.Nursing staff also completed nursing assessments, which included physical health screening. Managers and staff had made improvements and implemented standards to ensure that patients' physical health needs were considered and addressed.
- We saw an improvement in the completion of care records. They were organised, labelled and staff could easily find information within the file. The contemporaneous notes were mostly legible (except the signatures and role of staff). The entries reflected the patient's progress. There was assessment of patient presentation and staff documented views objectively.
- Care plans were detailed. Eleven of the thirteen care plans we examined were up to date and all were holistic. Staff documented relapse indicators.
- The doctor routinely assessed mental capacity for consent to treatment and there was an explanation recorded regarding how decisions were reached.
- The provider met weekly with the local NHS mental health trust. This included weekly visits by trust staff to review patient progress. The management team planned to develop improved communication with other services.

Summary of this inspection

Are services caring?

Requires improvement 

We rated caring as requires improvement because:

- We observed staff failing to respond to requests from patients in a timely manner. For instance, a patient knocked several times on the door of a staff room that was occupied by four members of staff. None of the staff responded to the knock on the door, remaining with their backs to the door.
- Four patients told us that members of staff sometimes fell asleep on duty when they were meant to be observing the patient.
- Two patients complained of staff bickering and gossiping about each other in front of them.
- Four patients commented on the difference between the care they received during the day and the care received during the night. They reported that at night, staff were not as caring and were less approachable.
- Three patients commented that staff did not always knock before entering their bedroom. For example, one female patient complained that male staff entered their bedroom without knocking just as they were stepping out of their shower. They said this made them uncomfortable.
- Where patients lacked capacity, staff did not routinely refer them to advocacy services.

However:

- Other patients reported that staff treated them in a kind and caring manner, offering time and support.
- Eight of the 14 patients that we spoke with told us that staff treated them with politeness, dignity and respect and supported them to access the local community.
- We saw evidence that staff involved patients actively in risk assessments, care planning and in their reviews. Staff provided patients with a copy of their care plan, which they kept in a file in their own bedroom.
- The provider sought patient feedback using questionnaires, community meetings and feedback boxes. Managers reviewed these findings at clinical governance meetings to help inform and improve care.

Are services responsive?

Requires improvement 

We rated responsive as requires improvement because:

Summary of this inspection

- Further work was required by managers to ensure consistency of decision making when assessing new admissions as suitable for admission. One patient was admitted to the hospital who had complex physical health needs having only days earlier been refused admission.
- Individual discharge plans did not always clearly identify which external professionals would be supporting the process, for instance, the patient's community care coordinator.
- Blanket restrictions were in place. For example, patients did not have a key to their bedroom, so if they chose to lock their bedroom door; staff had to open it on request.
- There were quiet rooms in the suite areas, but they appeared uninviting, the décor was bare and the rooms lacked warmth.We saw patients choosing to sit in corridors or in the large dining area when they lacked planned activity.
- Although the hospital had extensive grounds, they were restricted for safety. The enclosed courtyard was for people who smoked. There did not appear to be a safe place for people who did not smoke and were unable to access the gardens without escort, due to risk.
- The hospital recorded and reviewed complaints. We saw evidence of one bulletin which included learning from complaints which was planned to be issued weekly.

However:

- The care plans reviewed included relapse indicators and in many cases, there was a crisis plan. Where we found no crisis plan, it was for patients who were early in the admission, and this work was to be undertaken.
- Patients said the food served was excellent. Patients complimented the quality and quantity available.
- Two activity coordinators facilitated activities within the hospital. We saw efforts by staff to support patients' access to the community. There were few complaints of boredom.
- Patients were aware of how to make a complaint, and there were information leaflets and posters in ward areas. There had been 18 complaints in the 12-month period up to end April 2017. Four were upheld, seven not upheld, six partially upheld and one was on-going.

Are services well-led?

Inadequate

We rated well led as inadequate because:

- The provider failed to provide CQC with accurate pre inspection information about staffing. For example, the provider did not

Summary of this inspection

submit the correct percentage of trained nurse and support worker vacancies. For instance figures provided stated there was a vacancy of 1.75% for registered nurses. During inspection we saw a vacancy rate of over 80%.

- There was a serious incident of self-harm on the ward. This incident was reported by front line staff. The detail within the verbal account provided during the inspection was misleading. We challenged the provider who acknowledged that incorrect information had been given.
- Areas of risk to patients were not being managed effectively by the organisation. For example, the provider had not proactively identified areas of poor practice identified throughout this report. Internal audit and management systems had not identified areas of poor practice and how the service could improve.
- Managers were not managing poor staff performance effectively. We saw evidence in files of managers raising concerns with staff as issues arose, however, there were no clear plans to improve ongoing performance. Outcomes following discussions with staff were not clear. We raised this with the provider who acknowledged this was an area that required improvement.
- Staff were not aware of the organisation's stated visions and values. This meant that staff could not implement this in their everyday practice.

However:

- Managers completed some clinical audits. The findings of these audits were shared with staff.
- Senior governance of the organisation had been strengthened and there were plans to review the existing senior management arrangements.
- A system had been introduced to ensure that front line staff reviewed incidents and learned lessons from these.Senior managers had developed a bulletin with plans to produce this weekly for staff. There was some evidence of learning from incidents that had happened.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff completed Mental Health Act training and demonstrated a clear understanding of legal requirements and rights of those patients detained under the Act. Mental Health Act training was part of a mandatory programme for registered nurses only.
- Training compliance was 100%.
- Decision-specific assessments had not been considered when these may have been required. For instance, staff assessed a patient not to have capacity to consent to treatment but the patient had signed the consent to being searched by staff without a re-assessment of their capacity to make this decision.
- There was a Mental Health Act administrator two days a week based onsite. This person scrutinised the paperwork to ensure compliance with the Mental Health Act code of practice.
- Audits were undertaken and managers used findings to improve standards and inform learning.
- There was access to an independent mental health advocate (IMHA), and there were signs on notice boards within the building, advising patients of this.
- Where a patient lacked capacity, staff did not routinely refer them to the IMHA. It would be good practice to do so.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed mandatory Mental Capacity Act training, with completion at 91%.
- The hospital had made no deprivation of liberty safeguard applications in the six months prior to inspection.
- Staff knew the five principles of the Mental Capacity Act. However, some staff were unsure who would be responsible for carrying out assessments.
- The doctor routinely assessed whether patients had the mental capacity to consent to treatment and there was an explanation recorded regarding how decisions were reached.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

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

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Inadequate

Safe and clean environment

- We saw an up to date ligature assessment. Patient risk assessments needed to be reviewed in conjunction with the environmental risk assessment.
- The building was an old structure with many areas of obscured vision. There were many areas where a ligature could be fixed. A ligature point is a fixed fitting to which someone could tie an item to use for the purpose of self-strangulation. Managers had fitted mirrors to enable staff to see round corners more easily. This provided some mitigation to the risk posed by potential ligature points. There had been no incidents of self-harm by ligature since the hospital opened in February 2016.
- There was a plan on how to maintain the sharpness of ligature cutters. However, some staff were unclear of procedures. This posed a risk of the cutter not being sharp enough to be effective in an event that a ligature needed removing urgently.
- There was no environmental risk assessment for the outdoor areas and the grounds. There was not a clear plan on how staff managed these risks.
- Where staff had identified a problem with the ward environment that might pose a risk to patients, it took a long time for the maintenance department to respond to a request to put it right. We could not be assured that work was prioritised according to risk.
- We visited during the night of 19 June 2017. Outside the summer temperatures were very high. Within the building, the heat was overwhelming. We were concerned and so recorded room temperatures at 23:00hrs. All rooms were at least 26 degrees – including bedrooms. Two bedrooms were above 31 degrees. This was extremely uncomfortable. There were some fans available but insufficient to meet demand and to make a difference.
- The hospital complied with mixed sex guidance.
- The courtyard areas, which were separate for male and females, overlooked each other with clear lines of sight between the two. The area was used during the night time and was not supervised at all times. During our inspection, there was hot weather and we noted patients in minimal night clothing.
- The hospital was clean and furnishings were fit for purpose.
- The clinic room was clean, and staff checked equipment regularly. The emergency bag, however, contained two broken plastic containers that needed replacing.
- Staff had access to personal alarms. Specific staff also carried walkie-talkies to communicate with other team members, which was essential due to the building layout.

Safe staffing

- There was a high use of agency staff on the wards. At March 2017, sickness rates were less than 3% however staff turnover was 24% in the 12 month period leading to May 2017. Before the inspection, the data provided by the hospital stated that vacancies for nurses were 1.75% and support workers were 0.25%. During the inspection, the provider informed us that 63% of all shifts were covered by agency staff. We found that vacancy levels

for nurses were 88% and support workers were 64%. The provider partially mitigated these high vacancy rates with use of regular agency nurses who were offered short term contracts. We saw that regular agency staff received training similar to the permanent staff. Figures submitted for the period between 1 January 2017 and 31 March 2017 showed that no shifts were left unfilled. There were 180 shifts filled with agency workers.

- During the inspection, we saw there was one care support worker shift left unallocated on the night of 7 June 2017 due to sickness. The providers safer staffing board did not show one staff short within the staffing figures that day.
- During the night inspection, we saw sufficient numbers of staff to meet the needs of the patients.
- We saw flexibility regarding additional staffing. Staff knew the process for escalating requests in response to increased clinical acuity and we saw rota's that showed managers ensured sufficient staff were put in place to meet the extra demands.
- Staff were able to provide 1:1 time with patients and we did not see any evidence of leave being cancelled due to staff shortages.
- The hospital did not consider the gender of the patients when planning staffing and we did not see plans to mitigate this risk to the dignity and vulnerability of patients. For example, there were six male staff and three female staff on duty, with three male patients and 19 female patients. This meant the majority of patients received care from staff of the opposite sex. One of the female staff was allocated to the male suite, which compounded the issue.
- All staff were required to undergo training in prevention and management of aggression. However, some staff reported that at times they felt vulnerable and unsafe when managing patient aggression. The provider recognised this and told us that they intended to provide additional training to staff.
- There were two consultant psychiatrists and one specialist GP working at the hospital. There was an on call rota to ensure there was medical cover available to staff at night and weekends. There was also access to the local GP surgery. A 10-minute drive away there was a minor injuries unit. However, for events that were more serious, the main acute hospital was a significant distance away. Ambulance response time was about 30 minutes. To mitigate against this, the hospital provided immediate life support training to staff and the rota indicated who those people were. The rota showed us there was always at least one staff trained in immediate life support on duty on each shift.
- The records seen showed that mandatory training compliance met targets, with at least 90% of permanent staff having completed training.

Assessing and managing risk to patients and staff

- There were no seclusion facilities at Mundesley Hospital and there was no evidence seen of seclusion or long-term segregation taking place.
- The provider submitted data reported that there had been 44 incidents of restraint on 19 different patients for the period between 1 October 2016 and 31 March 2017. Five of the restraints were in the prone position and five patients required rapid tranquillisation treatment. The hospital did not have a formal restrictive intervention reduction programme but they told us that they had worked with staff to encourage de-escalation and reduce restraint.
- During the inspection period there was a serious incident where physical restraint took place that was not accurately recorded within the clinical notes as a restraint. These were allegations of the inappropriate manhandling of a patient. It was not reported to senior managers or through the incident reporting system. Following a complaint, the senior managers took appropriate action to report and investigate the incident. This failure by staff to report this incidence of restraint led us to question whether the number reported was an accurate indication of how often staff used restraint. This meant we could not be assured that patients were fully protected from abuse or improper treatment.
- Staff were trained in de-escalation skills and we saw evidence of staff using de-escalation techniques before having to use restraint.
- The records indicated that staff rarely used rapid tranquillisation. We reviewed two incidents and both provided a level of detail in the contemporaneous notes to assure that safe monitoring and practice was followed. However, staff were not using the national early warning score charts consistently to record the physical observations despite them being in the files.
- Staff had completed risk assessments on admission in thirteen of the fourteen records we reviewed. Staff regularly reviewed and updated the records when risk

increased, with the exception of falls screens and environmental risks. These were not routinely recorded. Following inspection, the provider told us a more comprehensive risk assessment had been put in place.

- The patient records contained risk assessments that staff had undertaken prior to a patient going on leave. There was no evidence of the patient receiving information on what they needed to do if they were struggling during leave, such as a contact number or distraction techniques to use (for those patients not accessing the crisis and home treatment team).
- Informal patients were not able to leave at will. There were leave forms, similar to those for patients who had been detained under the Mental Health Act, and the patient must agree to the leave arrangements. The provider had not ensured that informal patients' rights were protected.
- Although the hospital had beautiful grounds, they were restricted for safety. The enclosed courtyard was for people who smoked. For those patients who didn't smoke and were detained under the mental health act there was no access to fresh air unless escorted by staff.
- Staff requested that all patients signed a permission form to enable them to carry out a body search on admission and following leave from the hospital. This practice meant that staff searched patients without consideration of individual circumstance or risk. There was a serious incident relating to this practice which compromised a patient's dignity which the provider investigated. This related to an intimate search conducted by staff without a clear reason for doing so. Subsequently, the provider had reviewed this practice with a view to making changes to searching following leave. The changes had not been implemented at the time of our inspection. The provider continued to carry out body searches at admission.
- We saw inconsistencies in documentation of enhanced observations on the recording sheets. This meant we could not be sure that the staff carried out observation entries in a timely manner. For instance, one observation sheet provided basic information within a one-hour period indicating there were no concerns, however, there was an incident raised for that same period relating to the same individual. Some records identified a patient observation levels but did not provide a reason for the observations, nor was the information on the actual observation forms despite there being a prompt to do so.
- Four patients reported that staff sometimes fell asleep on duty when they were meant to be observing the patient. Failure to carry out observations could result in harm to the patient. We raised this with senior managers following the second part of the inspection.
- We saw there was one staff member less than was needed one night due to staff sickness. Plans were made to ensure that staff were aware of their responsibilities. However, one staff member had not follow instructions given by the nurse and carried out observations of all patients as directed. This also fuelled concern that observations may not have been carried out according to policy. We brought this to senior manager's attention.
- Records showed that all staff received training in safeguarding. Staff were able to describe the process and we saw evidence of safeguarding alerts completed. However, a serious incident demonstrated that some staff did not follow the training and guidance. These were allegations of the inappropriate manhandling of a patient.
- On two occasions, staff did not safeguard patients from abuse. Once senior managers were made aware of the concerns, the managers took immediate action. This included suspension of the staff members involved, informing the police and the local safeguarding team. An urgent board meeting was held and further assurance provided to commissioners and the Care Quality Commission.
- There was evidence that the provider ensured audit of medication management. However, the audit did not pick up the errors identified within this report.
- Medicines were stored securely and in accordance with the provider policy and manufacturers guidance. The fridge was kept locked and the temperature of the room and fridge was recorded daily. This room was air-conditioned. Where staff recorded the temperature out of the normal range, they took appropriate action.
- We found one box of medication that staff did not label correctly. Staff had written the name of the medication on the box saying the tablet strength was 2.5mg. We checked the contents and the box held 5mg tablets. There was a concern that this may have resulted in an administration of medication error. This box had been in use for a period of time and it had not been identified as an error. We raised this concern with the provider immediately for correction and investigation.

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

- Staff had opened bottles of medication but had not recorded the date of when two of the bottles had been opened and the new expiry dates were not recorded. This meant there was no way of telling when the bottles went out of date.
- The sharps bin was overfull. Another sharps bin which was also in use had not been labelled. We raised this with the registered nurse in the clinic room. When we went back on 19 June 2017 the sharps bin was correctly labelled but again was overfull.
- We reviewed 18 medication cards and all were completed correctly.
- We did not see any evidence of medication being out of stock. However, one patient did say that upon admission one item of regular medication was not available for a few days.
- The hospital provided a room for visiting, where children could access. There was no cleaning schedule for the toys, which needed addressing.

Track record on safety

- Prior to the inspection the provider did not submit any figures in relation to the number of serious incidents recorded in the 12 months to April 2017. During inspection the provider stated that there had been no serious incidents.
- During the same period CQC received 77 notifications in relation to the Hospital. The provider had reported two specific incidents to CQC during the same period which were an attempted suicide and an allegation of injury received during a restraint. These incidents were considered to meet the threshold of a serious incident in line with the NHS England's Serious Incident Framework.
- The provider had undertaken Root Cause Analysis (RCA) investigations for these and an additional incident during this period. We saw the RCA reports and the provider was able to evidence lessons learned in two of these cases. The remaining RCA had not been concluded.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident and what an incident was. However, we found one incident that had not been reported to senior managers or through the hospital reporting system.
- Senior managers had reported incidents to the CQC. We saw an improved system in place for reporting of incidents, restraint and rapid tranquilisation.
- Managers had introduced a system to ensure there was effective review of incidents and staff learned lessons. Senior managers had developed a bulletin with plans to produce this weekly for staff. We saw evidence of direct learning from an incident.
- Staff received training in the Duty of Candour during induction.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Following admission there was comprehensive and timely assessment of patients, usually within four hours of admission and always within 24 hours.
- Physical health examinations were undertaken and needs identified. Staff recorded these in the assessments and care plans. Nursing staff also completed nursing assessments, which included physical health screening upon admission. This was an area of concern during the inspection in January 2017. During this inspection, managers and staff had made improvements and standards were implemented to ensure that patients' physical health needs were considered and addressed.
- We saw an improvement in the order of the care records. They were organised, labelled and staff could easily find information within the file. The contemporaneous notes were mostly legible (except the signatures and role of staff). The entries reflected the patients' progress. There was assessment of patient presentation and staff documented observations objectively.
- Care plans were detailed. Eight of the ten care plans were up to date and all were holistic. Relapse indicators were recorded. There was evidence of crisis planning.
- Information was stored securely and was accessible to staff.

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

Best practice in treatment and care

- Patients did not have access to psychological therapies at the service. The hospital discussed their attempts to recruit a clinical psychologist and their further plans to fill this required post. However, we did not see evidence of any other psychology support such as staff trained in DBT (dialectical behaviour therapy), art therapy or psycho-educational therapies.

Skilled staff to deliver care

- Other than psychology, there was access to a range of disciplines and workers providing input to patients. This included doctors, nurses, clinical support workers, an occupational therapist and activity workers. There was also access to a discharge facilitator, social workers and access to services, when required, such as speech and language, dietician and other health professionals.
- Figures provided by the hospital showed compliance with supervision at 90%. From the HR records we reviewed, we did not see evidence that supported these figures.
- Appraisal figures provided where 75% and we saw the remainder booked in diaries.
- We saw evidence of training to ensure mandatory requirements for staff were met. It was less clear what specialist training was available.

Multi-disciplinary and inter-agency team work

- There were regular multidisciplinary meetings (MDT) held involving the patients. We did not see a system for inviting carers.
- The provider advised there was input directly to MDT meetings from the local Trust . We did not see evidence of attendance in care records we reviewed. The occupational therapist attended some patients' reviews.
- We observed a handover meeting which included a detailed account of current risks, observation levels, clarifying if a patient was informal or detained and physical health concerns.
- The provider met weekly with the local NHS mental health trust. This included weekly visits by trust staff to review patient progress. The management team planned to develop improved communication with other services.

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

- Figures provided by the hospital showed 100% compliance with Mental Health Act training, which was classroom based, for all registered nurses. This was supported but those HR file we examined.
- We saw evidence in all the files reviewed of consideration of mental capacity to consent to treatment. Where the assessment identified someone not to have capacity, the doctor documented the reason. The information the doctor recorded was detailed and considered. However, the assessing doctor deemed one patient to lack capacity but there had not been a review of this many weeks later.
- From six records reviewed, all six patients had their rights explained under the Mental Health Act. However, where the patient did not understand their rights, in two cases, staff did not repeat the rights for several days. The impact of this was that patients, particularly those on short-term sections, had less time to appeal against their detention.
- Five out of the six patients had detail in the care plan regarding capacity and consent to share information.
- There was strengthened governance process for scrutiny of detention papers.

Good practice in applying the Mental Capacity Act

- Staff completed mandatory Mental Capacity Act (MCA) training, with completion at 91%.
- We found that staff understood the principles of assessing capacity. However, there was confusion with some staff regarding who was responsible for carrying out capacity assessments for decisions not related to treatment.
- We saw in patient records that decision-specific assessments had not been considered where they may have been required. For example, staff assessed a patient not to have capacity to consent to treatment but the patient had signed the consent to searching on the same day, without an assessment of their capacity to make this decision.
- Staff assessed both detained and informal patients capacity regarding treatment and documented the outcome.
- There had not been any deprivation of liberty (DoLS) applications in the last six months.
- The hospital audited adherence to the MCA that showed 100% compliance.

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Requires improvement

Kindness, dignity, respect and support

- When staff engaged with patients, mainly they did so in a kind and caring manner, offering time and support.
- Most patients we spoke with said staff treated them with politeness, dignity and respect and supported them to access the local community.
- We spoke to one carer and received feedback via comment cards from other carers. We were told that staff were approachable and caring. One carer said they felt their relative was in safe hands.
- Two patients said it was the best hospital they had stayed at.
- Two patients reported that staff bickered amongst themselves in front of patients and berated patients in front of other patients. They also said they heard staff gossiping about each other.
- Staff ate with patients at mealtimes and used this as an opportunity to interact with patients. However, one morning, we saw several staff eating breakfast together while a patient was waiting at the door wanting to enter the dining area. On another occasion, a patient knocked on the staff room door where there were four members of staff. None of the staff responded to the knock, remaining with their backs to the door. The patient waited, until a staff member outside the room attended to their needs.
- Four patients reported that staff sometimes fell asleep on duty when they were meant to be observing the patient. Failure to carry out observations could result in harm to the patient. We raised this with senior managers following the second part of the inspection.
- Four patients commented on the difference between the care they received during the day and the night time care. They reported that at night, staff were not as caring and were less approachable. We raised this with senior managers after our follow up inspection of the night of 19 June 2017. Managers reviewed feedback with a view to addressing this concern.

The Involvement of people in the care they receive

- Patients received a welcome pack and were orientated to the building on admission.
- We saw evidence of active patient involvement in risk assessments and care planning and participation in their reviews. Staff provided patients with a copy of their care plan, kept in a folder in the patient's own bedroom.
- Patients were able to access advocates and there were posters on the notice boards advising of this.
- Where patients lacked capacity, staff did not routinely refer them to advocacy services.
- There were weekly community meetings. Various staff attended this meeting with the patients. For instance, the chef attended to receive feedback about the quality of the food. We reviewed the notes of the meetings and found that whilst staff addressed many issues raised by patients, some did not appear to be addressed and patients raised the same concerns more than once.
- The provider sought patient feedback via a range of avenues. This included a comments box, community meeting and patient experience survey. The comments were reviewed at governance meetings to help inform and improve care.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Requires improvement

Access and discharge

- Further work was required by managers to ensure consistency of decision making when assessing new admissions as suitable for admission. One patient was admitted to the hospital who had complex physical health needs having only days earlier been refused admission.
- Individual discharge plans did not always clearly identify which external professionals would be supporting the process, for instance, the patient's community care coordinator.
- The provider submitted figures showing that between December 2016 and March 2017 bed occupancy was 102%. We saw that bed occupancy after this date fell and there were eight empty beds at the time of this inspection.

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

- Patients who accessed leave always had a bed available upon their return. Patients did not move rooms unless it was to meet their clinical needs.
- The care plans reviewed included relapse indicators and in many cases, there was a crisis plan. Where we found no crisis plan, it was for patients who were early in the admission, and this work was to be undertaken.

The facilities promote recovery, comfort and dignity and confidentiality

- There were quiet rooms in the suite areas, but they appeared uninviting, the décor was bare and the rooms lacked warmth. We saw patients choosing to sit in corridors or in the large dining area when they lacked planned activity.
- There were sufficient rooms to support treatment and care. The lounge had a large TV but patients reported not being able to agree on what to watch so didn't tend to use it. We saw patients choosing to sit in corridors or in the large dining area when they lacked planned activity.
- The extensive grounds were restricted based on risk and patients were frequently escorted by staff when accessing fresh air.
- Blanket restrictions were in place. For example, patients did not have a key to their bedroom, so if they chose to lock their bedroom door; staff had to open it on request.
- During the evenings and weekends patients reported there was less to do.
- Patients said the food served was excellent. Patients complimented the quality and quantity available.
- There was access to hot and cold drinks until midnight. After that, drinks were available upon request.
- Two activity coordinators facilitated activities within the hospital. We saw efforts by staff to support patients' access to the community. There were few complaints of boredom.

Meeting the needs of all people who use the service

- The environment was not accessible for people with physical disabilities. The provider managed this by pre-assessing all new admissions. The provider made some reasonable adjustments, but the hospital was not able to meet the needs of people with complex physical disability needs.
- There were no specific measures in place to translate paperwork such as care plans and risk assessments. However, we saw staff use language interpretation services for a patient
- Information was accessible to patients on notice boards and via leaflets available in the reception area. This ranged from information about patients' rights, access to local services, the complaints process and healthy living literature.
- The menu was varied, and patients discussed it with the chef at the weekly community meeting. Adjustments were made to meet individual dietary spiritual and cultural needs.
- There was access to appropriate spiritual support for patients.

Listening to and learning from complaints

- The hospital logged and reviewed complaints. A weekly bulletin was in development which included lessons learned from complaints when appropriate. We saw one bulletin and there were plans to develop this.
- Patients were aware of how to make a complaint, and there were information leaflets and posters in ward areas. There had been 18 complaints in the 12-month period up to end April 2017. Four were upheld, seven not upheld, six partially upheld and one was ongoing.
- Senior staff discussed feedback from complaints at governance meetings.
- We saw notes from the community meetings and action taken to address concerns raised by patients during these meetings.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Inadequate

Vision and Values

- Staff were not aware of the organisation's stated visions and values. This meant that staff could not implement this in their everyday practice.
- Most staff knew who the senior managers were and they were visible and approachable within the hospital.

Good governance

Acute wards for adults of working age and psychiatric intensive care units

Inadequate

- The provider failed to provide CQC with accurate pre inspection information about staffing. For example, the provider did not submit the correct percentage of trained nurse and support worker vacancies.
- During inspection figures provided for completion of supervision was over 90% but staff files we saw did not reflect this.
- Areas of risk to patients were not being managed effectively by the organisation. For example, the provider had not proactively identified areas of poor practice identified throughout this report. Internal audit and management systems had not identified areas of poor practice and how the service could improve.
- There was a serious incident of self-harm on the ward. This incident was reported by front line staff. The detail within the verbal account provided during the inspection was misleading. We challenged the provider who acknowledged that incorrect information had been given.
- Managers were not managing poor staff performance effectively. We saw evidence in files of managers raising concerns with staff as issues arose, however, there were no clear plans to improve ongoing performance. Outcomes following discussions with staff were not clear. We raised this with the provider who acknowledged this was an area that required improvement.
- The hospital did not effectively address performance issues with agency staff.
- We saw that the hospital stopped using agency staff if there were significant concerns.
- The provider's risk register required reviewing to ensure that it included all the identified risks to the organisation.
- Governance arrangements for frontline staff were not robust. For example, there was no system for monitoring whether staff had undertaken required duties. One staff member we spoke with had not followed instructions and carried out enhanced patient observations for one hour. Senior staff on duty were not aware of this.
- Staff reporting structures were unclear. This meant that some staff reported their concerns directly to senior managers and did not inform the nurse in charge of their individual concern. This meant that senior nursing staff were not identifying concerns quickly enough.
- The provider had not ensured that all incidents were reported in line with their own policy.
- There was a lack of evidence in the staff files to support the provider's reported supervision rates. Some records showed staff had received just three supervisions in12 months.
- Most staff were up to date with their mandatory training. This was supported by those records seen. Sessions planned for the remaining staff.
- The appraisal completion rate was 75%, with just two staff outstanding. This was supported by those records reviewed.
- Managers completed some clinical audits. The findings of these audits were shared with staff.
- Senior governance of the organisation had been strengthened and there were plans to review the existing senior management arrangements.
- A system had been introduced to ensure that front line staff reviewed incidents and learned lessons from these. Senior managers had developed a bulletin with plans to produce this weekly for staff. There was some evidence of learning from incidents that had happened.
- There had been an appointment of a ward clerk to assist the teams to carry out administrative tasks.

Leadership, morale and staff engagement

- The hospital had an informal feel and staff spoke of a family environment. There was evidence that this affected staff's own professional approach. This meant that staff did not always respond to patients who sought assistance in a timely manner.
- Most staff knew the whistleblowing policy although some said they would not feel comfortable using it. Staff explained this was due to the organisation being small and they feared that it would be difficult for their individual concern to be kept confidential.
- The recent staff survey results showed that 23% of staff were unhappy at work. The key concern related to poor communication. Managers had begun to formulate a plan on how to address these concerns and a staff meeting had been held to discuss findings.
- There had been no bullying and harassment cases recorded. However; we saw that there were occasions when a concern had been raised internally.
- The recent staff survey results showed that frontline staff were appreciative of their colleagues and enjoyed a positive team-working atmosphere.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that all medication is correctly labelled and that the medication in the box matches the label.
- The provider must ensure use of the sharps bin complies with safety standards
- The provider must ensure that the nursing assessment includes screening for falls
- The provider must ensure completion of all the malnutrition universal screening tool (MUST) assessments.
- The provider must ensure there are systems and procedures in place to prevent abuse of patients and these are effectively operated.
- The provider must provide the correct information relating to staffing, incidents and evidence of supervision completion.
- The provider must ensure that all incidents are reported via their internal reporting process.
- The provider must ensure that staff treat patients with dignity and respect at all times.
- The provider must ensure that staff conduct is monitored and performance managed to provide a skilled, compassionate, responsive workforce.
- The provider must ensure that enhanced observations are recorded accurately.
- The provider must ensure that staff are able to access effective management supervision.
- The provider must address performance issues with agency staff.
- The provider must ensure that staff are able to recognise and raise safeguarding concerns.
- The provider must ensure that staff understand the legal framework for the use of restraint and where there are concerns these are reported immediately.
- The provider must ensure patients have access to psychological therapies.
- The provider must ensure that a patient detained under the Mental Health Act who lacks capacity is referred to an independent mental health advocate.

Action the provider SHOULD take to improve

- The provider should ensure there is secure outside space for patients who do not smoke and are unable to access leave.
- The provider must ensure that where a patient has been assessed as lacking capacity to treatment, other areas requiring patient consent are also assessed.

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 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider did not ensure that staff treated patients with dignity and respect at all times. This was a breach of regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The provider did not ensure that a patient detained under the Mental Health Act who lacks capacity was referred to an independent mental health advocate. This was a breach of regulation 11

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not ensure the proper and safe use and disposal of medicines and medical equipment • The provider did not ensure enhanced observations were recorded accurately • The provider did not ensure that staff understood the legal framework for use of restraint and the requirement to report any concerns

This section is primarily information for the provider

Requirement notices

- The provider did not ensure that the nursing assessment included screening for falls
- The provider did not ensure completion of all the malnutrition universal screening tool (MUST) assessments.
- The provider did not ensure that patients had access to psychological therapy.

This was a breach of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

- The provider did not ensure there were systems and procedures in place and these were effectively operated to prevent abuse of patients
- The provider did not ensure staff adhere to safeguarding procedures and report any concerns

This was a breach of regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The provider did not provide the correct information relating to staffing, incidents and evidence of supervision completion to the Care Quality Commission.

This section is primarily information for the provider

Requirement notices

- The provider did not ensure that staff conduct was monitored and performance managed to provide a skilled, compassionate and responsive workforce.
- The hospital did not effectively address performance issues with agency staff.
- The provider did not identify areas of poor practice identified throughout this report using their internal audit processes.
- The provider did not ensure that all incidents were reported via their internal reporting process

This was a breach of regulation 17

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 Regulation 18 HSCA (RA) Regulations 2014 Staffing

- The provider did not ensure that all staff were able to access managerial supervision.
- The provider did not always ensure that staff performance was monitored

This was a breach of regulation 18