The Huntercombe Hospital - Roehampton

Quality Report

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

Ratings

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

Summary of findings

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

Overall summary

The CQC is placing the service into special measures.

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

During this inspection, we found that the service had addressed some of the issues we found following the August 2016 inspection. However, we also identified a number of serious concerns about the safety and quality of the service. Some of these were areas of continuing non-compliance and others were new concerns.

We rated the service **inadequate** overall because:

- Staff at this service used rapid tranquilisation regularly on patients. We found in 24 of the 35 incidents of rapid tranquilisation, staff did not follow best practice guidance in relation to monitoring the physical health of patients after rapid tranquilisation. Staff did not record patients' vital signs every 15 minutes for the first hour and every hour until ambulatory as per the service's policy. The lack of physical health monitoring post rapid tranquilisation meant patients were at risk of avoidable harm.
- At the previous inspection in August 2016, we found that staff did not always consistently record the reasons why a patient's risk had changed. At this inspection, we found this had not improved. Patient risk assessments did not show the reason why the patient's assessed level of risk had changed. We also found at this inspection that where patients had specific risks there were not always management plans in place.
- At the previous inspection in August 2016, we found that staff did not always record the reasons for administering 'as required' medicines to patients. At this inspection, we found this had not improved on Upper Richmond Ward.
- Staff did not meet patients' physical health needs. Staff did not consistently record patients' daily National Early Warning Scores (NEWS) to assess and monitor patients' physical health risks and escalate concerns when their patient might be deteriorating. The service had no arrangements in place for staff to encourage patients to give up smoking or refer patients on to smoking cessation services.
- Staff imposed an inappropriate and unsafe blanket restriction on the wards. A water cooler in the communal areas did not have cups available for patients to use to get themselves a drink of water. Staff said they locked cups away due to the risk of some patients using plastic cups to self-harm. However, removing the cups altogether put all patients at risk of dehydration.
- At the last inspection in August 2016, we found that staff used a high number of agency staff. At this inspection, we found that, whilst recruitment was taking place, this still needed to improve. The service had experienced a recent increase in the use of agency staff, due to an increase in acuity of patients and increase in the staffing establishment.
- Staff did not complete up to date ligature risk assessments and could not always identify where ligatures were present on the wards and how patients would be kept safe.
- Staff did not report all incidents that should be reported. This included some incidents of physical restraint.
- We observed that sometimes staff did not effectively engage patients when they started to become

Summary of findings

aggressive or aroused. We observed staff telling patients to 'calm down' when they became agitated rather than using effective de-escalation techniques. Staff engaged minimally with patients when carrying out one-to-one observations. The service had not yet implemented a reducing restrictive practices programme on the wards to reduce violence and aggression.

- At the previous inspection in August 2016, we found that staff did not complete personalised care plans. Staff did not accurately reflect the individual needs and preferences of the patient. At this inspection, we found this had not improved. Patients had generic care plans that only referred to their mental state and did not always include patients' specific needs or reflect their preferences.
- Patients shared bathrooms. Each bathroom had a small panel on the outside of the door for staff to observe patients in the bathrooms. On Upper Richmond Ward, we found that all panel covers were open and three out of the seven covers were broken and therefore could not be closed. This meant that any person walking past the bathroom door could peer in. This did not promote privacy for the patients.
- The service did not provide any activities at weekends.
- We concluded that senior managers in the hospital did not have the skills, knowledge and experience to provide leadership of the quality required to maintain safe and effective care. Ward managers could not explain how they maintained quality and ensured that care met fundamental standards.
- Governance arrangements were not robust and quality assurance processes did not ensure that patients and staff were kept safe. For example, the managers did not have clear oversight of the use of rapid tranquilisation and high dose antipsychotic therapy across the hospital. Ward staff team meetings did not have a standard agenda and this meant that opportunities to discuss incidents and complaints did not always take place, which could impact on the ability of ward staff to learn and improve the safety of the service. The service risk register did not contain the pertinent risks that faced the wards.
- Systems to provide assurance were not working well. At the last inspection, in August 2016, we found that audits did not contain a clear plan when improvements were needed. At this inspection, this had not improved. Managers conducted audits but they had no specific timescales for when staff needed to complete actions by. The provider was not monitoring whether improvements were taking place as needed. Staff had not fully implemented the requirements and recommendations from the past two CQC inspections.
- Whilst the service had systems in place to engage and receive feedback from staff, patients and relatives they were not working effectively. The provider's staff survey 2018 had a low response rate at only 28% of staff completing it. No relatives had completed the friends and family survey. On the wards patients did not receive clear feedback on whether concerns raised at community meetings had been addressed.

However:

- At the last inspection in August 2016, we found that the provider did not keep cleaning records up-to-date or ensure that all areas of the ward were kept clean. At this inspection, we found this had improved. Staff kept cleaning records up-to-date and cleaned the ward environment.
- The provider had procedures in place to address safeguarding concerns and staff had received training in safeguarding adults. Staff reported patient on patient assaults as a safeguarding concern. The service had fully equipped clinic rooms with emergency equipment checked regularly. Seclusion facilities allowed clear observation and two-way communication, and had washing facilities. The layout of the wards allowed staff clear lines of sight to observe patients at all times when in the communal areas.
- The service had a full range of multidisciplinary staff to provide care and treatment to patients. Staff received regular managerial supervision. Staff morale was good and staff reported feeling supported by their managers and teams. The service had recently set up an academy for staff to attend further training. Staff mandatory training had improved at the service and the majority of staff had completed training to keep patients safe from harm and abuse.
- Patients completed an annual survey to provide feedback on the service they received. The response was largely positive.

Summary of findings

- Each ward had a full range of facilities and rooms available to safely provide care and treatment to patients. The service had a fully equipped gym for patients to use. Patients had access to basic mobile phones to make phone calls in private.
- Staff spoke positively about being supported by their managers and working as a team. Staff received regular supervision in line with the provider's policy.

Due to the concerns we had after the inspection, we asked the provider to take immediate action. This was because we were concerned the service did not adequately assess and manage the risk of patients. The service did not provide patients with access to drinking cups to get themselves a drink of water. The service did not ensure staff carried out the required rapid tranquilisation physical health monitoring on all patients. The service did not safely manage medicines. The service needed to address this by 21 June 2018. We also had concerns that the service did not ensure patients' care plans were personalised and met their needs. The service needed to address this by 12 July 2018.

Summary of findings

Contents

Inadequate

The Huntercombe Hospital-Roehampton

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units

Summary of this inspection

Background to The Huntercombe Hospital - Roehampton

The Huntercombe Hospital-Roehampton is provided by Huntercombe (No13) Limited. It is registered to provide the following regulated activities:

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

• Accommodation for persons who require nursing or personal care;

• Diagnostic and screening procedures; and

• Treatment of disease, disorder or injury.

The service provides 39 psychiatric intensive care (PICU) beds for patients on one male-only and two female-only wards. On the days of inspection, there were 38 patients in the hospital.

Kingston Ward is a 14 bed male-only ward; Upper Richmond Ward is a 14 bed female-only ward and Lower Richmond Ward opened in March 2018 as an 11-bedded complex care step down ward for female patients. At the time of the inspection, only one patient was considered a complex care patient. All patients were detained at the time of the inspection.

We have inspected Huntercombe Hospital-Roehampton seven times since 2010. Reports of these inspections were published between March 2012 and November 2016.

At the last inspection in August 2016, we followed up the breaches from the July 2015 inspection where the service was rated requires improvement. The service required improvement in the safe, effective and well-led domains. The regulations breached were Regulation 9 person-centred care and Regulation 12 safe care and treatment.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an inspection manager, an assistant inspector, three specialist advisors with a background in psychiatric intensive care units and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme and to follow up the concerns identified at the last inspection in August 2016.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location. This inspection was unannounced, which meant the provider did not know we were coming.

Summary of this inspection

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 11 patients who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with 15 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker;
- spoke with an independent advocate;
- attended and observed two multi-disciplinary meetings;
- looked at 11 care and treatment records of patients:
- carried out a specific check of the medicine management on each ward; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with 11 patients. Patients gave us mixed feedback about how the staff treated them. Five patients said that staff were not always caring and polite towards them. One patient said that staff spoke to each other in their own language in front of them and they could not understand what they said. Another patient said that staff did not always occupy them in meaningful activities when on one-to-one nursing observations. A patient on Lower Richmond Ward told us that they did not like the way that staff restrained them as it hurt.

Four patients said that staff treated them with respect and tried to help them. These patients said they felt safe on the wards. One patient on Upper Richmond Ward said that they had a positive experience when being restrained. Staff had explained to them why they used physical restraint and the patient understood it was for their safety. Most patients said staff knocked on the door before entering their bedrooms.

The service conducted a patient survey 2018. Twenty-two patients responded. Of these respondents, 63% said they would recommend the service to family and friends. Sixty two per cent said they could approach staff for support. Sixty-five percent felt staff listened to them and 82% felt involved in decisions about their care and treatment. However, only 33% reported they could meet members of the clinical or care team.

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:

- Staff at this service used rapid tranquilisation regularly on patients. We found in 24 of the 35 incidents of rapid tranquilisation, staff did not follow best practice guidance in relation to monitoring the physical health of patients after rapid tranquilisation. Staff did not monitor or record patients' vital signs every 15 minutes for the first hour and every hour until ambulatory in line with the provider's policy on rapid tranquilisation. Patients receiving rapid tranquilisation are at risk of seizures, airway obstruction, excessive sedation and cardiac arrest. The lack of physical health monitoring post rapid tranquilisation meant patients were at risk of avoidable harm.
- At the previous inspection in August 2016, we found that staff did not consistently record the reasons why a patient's risk had changed. At this inspection, we found this had not improved. Patient risk assessments did not record the reason why the patients' assessed level of risk had changed. In addition, identified risks did not always have a clear management plan in place.
- Staff imposed an inappropriate and unsafe blanket restriction on the wards. A water cooler in the communal areas did not have cups available for patients to use to get themselves a drink of water. Staff locked cups away due to the perceived risk of some patients using plastic cups to self-harm. This decision was not based on individual risk and was a blanket restriction. The removal of cups put all patients at risk of dehydration.
- At the previous inspection in August 2016, we found that staff did not always record why they administered 'as required' medicines to patients. At this inspection, we found this had not improved on Upper Richmond Ward. Staff did not record why they administered 'as required' medicines to patients.
- We observed that staff did not effectively engage patients when they started to become aggressive or aroused. We observed staff telling patients to 'calm down' when they became agitated rather than using effective de-escalation techniques.
- Staff used the National Early Warning Score (NEWS) to assess and monitor patients' physical health risks. The provider's policy was to complete NEWS daily on every patient. However, staff did not accurately complete NEWS on patients every day in line with the policy which could mean deterioration in the patients' physical health might not be escalated as needed.

Summary of this inspection

- Staff completed ligature risk assessments for each ward. However, staff did not identify some ligature anchor points on these assessments, such as door hinges. Staff could not explain how patients' safety was maintained when ligature risks were present.
- Staff did not report safety incidents that happened such as the use of restraint. Learning from incidents did not routinely take place at team meetings.
- At the time of the inspection, the service had a high number of agency staff employed to support patients. A permanent member of staff felt that this affected patient care because agency staff could not always safely manage patients who were violent and aggressive.

However:

- At the last inspection in August 2016, we found that the provider did not keep cleaning records up-to-date or ensure that all areas of the ward were kept clean. At this inspection, this had improved. Staff kept cleaning records up-to-date and the ward environment was visibly clean.
- The provider had procedures in place to address safeguarding concerns and staff had received training in safeguarding adults. Staff reported patient on patient assaults as a safeguarding concern.
- The service had fully equipped clinic rooms with emergency equipment checked regularly. Seclusion facilities allowed clear observation and two-way communication, and had washing facilities.
- The layout of the wards allowed staff clear lines of sight to observe patients at all times when in the communal areas.

Are services effective?

Requires improvement

We rated effective as **Requires Improvement** because:

- At the previous inspection in August 2016, we found that staff did not complete personalised care plans with patients. Staff did not accurately reflect the individual needs and preferences of the patient. At this inspection, we found this had not improved. Patient care plans did not identify their specific needs or reflect their preferences. Some care plans did not show that staff met patients' physical health needs.
- The service had no arrangements in place for staff to encourage patients to give up smoking or to refer patients to smoking cessation services. Many patients came to the service from an NHS hospital and would probably transfer back to an NHS

Summary of this inspection

hospital, where they would not have been able to smoke. Patients may have already been using nicotine replace therapies to help stop smoking and address their tobacco addiction but been unable to continue.

However:

- The service had a full range of multidisciplinary staff to provide care and treatment to patients. Staff had received an annual appraisal of their work performance and received regular managerial supervision. Records showed staff had received supervision every eight weeks in line with the provider's policy.
- The provider had recently set up the Huntercombe academy for staff to attend. Staff had completed National Vocational Qualifications through the service and a staff member had completed a leadership course.

Are services caring?

Requires improvement

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

- Patients shared bathrooms. Each bathroom had a small panel on the outside of the door for staff to observe patients in the bathrooms. On Upper Richmond Ward, we found that all of the panel covers were open and three out of the seven covers were broken and therefore could not be closed. This meant that any person walking past the bathroom door could peer in. This did not promote privacy for the patients.
- We observed some poor interactions between patients and staff. Staff only engaged minimally with patients when carrying out one-to-one observations.
- The provider did not invite families and carers to patients' multidisciplinary reviews. Families and carers needed to arrange a separate appointment with staff to provide feedback and gain information about their relative.
- Staff did not always involve patients in planning their care. Care plans did not contain the patient voice and patients said that staff did not attempt to involve them in contributing to their care plan.
- Five patients told us that staff did not always treat them with dignity and respect.

However:

- Patients completed an annual survey to provide feedback on the service they received. Twenty-two patients responded with mostly positive responses. Patients attended fortnightly community meetings to provide staff with feedback about the service.

Summary of this inspection

Are services responsive?

Good

We rated responsive as **good** because:

- Staff planned for patients' discharge, including liaison with the patient's home NHS trust as well as their funding authority and the patients' care co-ordinator.
- Each ward had a full range of facilities and rooms available to safely provide care and treatment to patients. The food met patients' dietary requirements and was of good quality. Patients could also have their own basic mobile phone following a risk assessment.
- Patients had access to spiritual support as needed. Staff displayed details of the local places of worship and had a multi-faith room for patients who did not have leave.
- The ward environment could meet the needs of the patients. The service had a fully equipped gym and staff received training in this to support patients at the gym.
- Staff investigated patient complaints and provided patients with a written response as per the provider's policy.

However:

- Staff did not routinely discuss complaints made by patients at the clinical improvement group meetings or staff meetings.
- The service did not provide any activities at weekends. Two patients said they would like activities at the weekends as patients felt bored during this time.

Are services well-led?

Inadequate

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

- Governance arrangements were not robust and quality assurance processes did not ensure patients and staff were kept safe. For example, the hospital managers did not monitor the use of rapid tranquilisation and high dose antipsychotic therapy being used in the service to meet the needs of the patients who had very complex needs. Managers had not ensured that staff knew how to manage potential risks to patients from ligature points.
- Whilst there was a meeting in place to look at incidents for the hospital, the learning from incidents was not consistently shared with ward staff. The service did not have a clear framework of what must be discussed at a ward level to ensure essential information was shared with staff. Staff team meetings had no standard agenda. This meant that essential learning from incidents and complaints to improve the safety of the care and treatment might not take place.

Summary of this inspection

- Systems to provide assurance were not working well. At the last inspection, in August 2016, we found that audits did not contain a clear plan when improvements were needed. At this inspection, this had not improved. Managers conducted audits but they had no specific timescales for when staff needed to complete resulting actions by.
- The provider was not monitoring whether improvements were taking place as needed. Staff had not fully implemented the requirements and recommendations from the past two CQC inspections. This included areas that potentially were a risk to patient care including the appropriate use of risk assessments and some aspects of medicines management.
- The service risk register did not include all pertinent risks found during the inspection. Some ward managers did not know about the risk register, or how to escalate concerns where needed.
- Whilst the service had systems in place to engage and receive feedback from staff, patients and relatives they were not working effectively. The provider's staff survey 2018 had a low response rate at only 28% of staff completing it. No relatives had completed the friends and family survey. On the wards patients did not receive clear feedback on whether concerns raised at community meetings had been addressed.
- We concluded that senior managers in the hospital did not have the skills, knowledge and experience to provide leadership of the quality required to maintain safe and effective care. Ward managers could not explain how they maintained quality and ensured that care met fundamental standards. Two of them expressed limited understanding of their ward, how they met the holistic needs of patients and how they kept them safe.

However:

- Staff morale was good and staff reported feeling supported by their managers and teams. The provider conducted a yearly staff survey. Those staff who did respond to the staff survey gave positive answers.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff understood their roles and responsibilities under the Mental Health Act 1983, the code of practice and its guiding principles.
- The service had a dedicated Mental Health Act administrator who provided support to staff and advice on the implementation of the Act.
- Staff authorised and administered medicines for detained patients in line with the Mental Health Act Code of Practice.
- Staff explained to patients their rights under the Mental Health Act in a way they could understand.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care.
- Staff completed capacity assessments for patients that might have impaired capacity. These were time and decision specific.

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	Good	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Good	Inadequate	Inadequate

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

Inadequate

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

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

Inadequate

Safe and clean environment

- The building had one main entrance into a main reception area followed by secured doors to each ward. Upper Richmond and Kingston Wards were located on the first floor and Lower Richmond located on the ground floor. Entry to the wards required a key fob to permit access through two doors. It was staff practice for one door to be opened at a time creating an 'air lock'.
- Staff undertook regular environmental checks to identify potential risks throughout the day. Staff recorded and reported on any areas, which required attention, for example spillages or broken items of equipment and missing cutlery.
- The ward layout meant that staff could observe each corridor from the nursing station. There were clear lines of sight to the main communal areas and to the corridors where patient bedrooms were located.
- There were ligature risks on all three wards. A ligature anchor point is an environmental feature or structure, to which patients may fix a ligature with the intention of harming himself or herself. All wards had a ligature risk assessment dated March 2018, identifying ligatures in each room on the ward. However, we noted that staff did not document all ligature risks. For example, staff had not identified bedroom door hinges and plastic casing outside some patient bedrooms on the ligature risk assessment dated March 2018. Some staff on Lower Richmond Ward were unaware of the ligature risks present on the ward. They were unable to describe what the risks were or where they were located. Therefore, staff could not manage and reduce the risks to patients. Each ward provided one set of ligature cutters, located in the nursing offices.
- The wards were each single sex accommodation.
- The provider issued all members of staff with a personal alarm. Alarms could be easily activated and assistance summoned immediately. Reception staff tested alarms each week to check they worked.
- Patients had access to a call alarm in their bedroom.
- The service had a yearly fire risk assessment completed by an external fire safety organisation. We looked at the recent risk assessment dated November 2017. The risk assessment provided action points for the hospital manager to address and these were completed. Fire extinguishers had been serviced and were within date. Staff conducted fire drills twice a year and weekly fire alarm testing. Each ward had designated fire wardens to ensure patient safety during a fire.

Maintenance, cleanliness and infection control

- At our last inspection in August 2016, we found that cleaning schedules were not kept up-to-date and did not record when they had cleaned areas of the ward. The wards were visibly unclean. At this inspection, we found improvements had been made. Staff kept cleaning records up-to-date and demonstrated staff cleaned the ward areas regularly. The wards had full time domestic staff to support with keeping the wards clean. The unit was visibly clean and clutter free. Managers, staff and patients all reported that the wards usually appeared clean and maintained to a good standard.

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

Inadequate

- The patient led assessment for the care environment (PLACE) scored the service at 97% for cleanliness.
- Staff adhered to infection control principles, including handwashing and wearing appropriate personal protective equipment, such as disposable gloves. Staff used a yellow plastic bin to dispose of clinical needles and sharps. Staff kept the yellow bins in the clinic rooms, dated and not over-full. All staff completed training on infection control. However, staff did not keep a record of the patients' food fridge temperatures to check that food was stored at the correct temperature.

Seclusion room

- Kingston and Upper Richmond Wards each had dedicated seclusion rooms. The rooms allowed clear observation and two-way communication, and had toilet facilities and a clock. A notice was on the wall outlining to patients how seclusion worked and the checks they would receive whilst in seclusion. The two seclusion room facilities followed the Mental Health Act Code of Practice.

Clinic room and equipment

- All wards had a fully equipped clinic room. The clinic rooms were tidy, well organised with accessible resuscitation equipment. Staff kept an emergency grab bag containing lifesaving equipment in the treatment room, such as oxygen cylinders. Staff checked and replenished the bags after use. Each clinic room had an automated external defibrillator (AED) for staff to use if a patient's heart suddenly stopped beating. Records showed that staff checked emergency equipment weekly. Staff stored medicines, including controlled drugs, safely. Medicines were stored correctly and a sample we checked was in date. Staff destroyed controlled drugs in accordance with hospital policy.
- Staff maintained medical equipment stored in the clinic rooms. Staff labelled equipment with the date it had last been checked and calibrated. Staff included cleaning equipment as part of their daily checklist to maintain hygiene. Staff signed a sheet each week to confirm the clinic room had been cleaned. The hospital had 'I am clean' stickers available for use. However, we did not see them placed on items of equipment. Therefore, the staff did not clearly display the dates they last cleaned items. Staff checked the medicines fridge and room temperature readings each day to keep medicines at a safe temperature. Daily records of the clinic room demonstrated that staff maintained temperatures within an appropriate range, and where temperatures went out of range this was addressed.

Safe staffing

Nursing staff

- The ward managers calculated the number and grade of nurses and healthcare assistants required to keep patients safe. The hospital manager told us that the provider had recently reviewed the staffing establishment due to the recent increase in the number of patients admitted. The hospital adjusted staffing levels according to patient acuity. At the time of the inspection, the service had a total of nine vacancies for nursing staff and 24 vacancies for healthcare assistants. The number of vacancies for healthcare assistants had just increased from 14 vacancies. The hospital manager had approval to recruit more healthcare assistants due to the increase in number of patients and one-to-one nursing observations.
- The ward managers could adjust staffing levels on a daily basis to meet the needs of the patients on the wards. The ward operated on two 12-hour shift patterns. Each ward had two qualified and three unqualified staff during the day shift and two qualified and two unqualified staff during the night shift. The manager had the flexibility to increase staffing levels to cover enhanced observations and patient escorted leave. Where one patient required increased observation levels, the ward numbers would absorb this. The ward managers could then increase staffing levels when more than one patient was on increased observation as well as for escorted leave. Ward managers met every day to organise cover where there might be any gaps in the staff rota for the following day.
- At our last inspection in August 2016, we found that the ward used a high number of agency staff. At this inspection, we found that the service still used a high number of agency staff. Agency usage across the hospital was high due to vacancies as well as the number of patients who required enhanced observation. We looked at the use of agency staff in the service for April 2018. Agency nursing staff filled 1204 shifts. One permanent staff member commented on the lack of agency staff's ability to manage patient violence and aggression effectively. Some staff could not identify

ligature points on the wards, which affected patient care and safety. To ensure continuity of care the hospital manager booked the same agency staff and supplied them with short-term contracts and training.
- Agency and bank staff received an induction to familiarise them with the ward. The bank or agency nurse completed a checklist to demonstrate a member of staff had inducted them to the ward.
- We checked the personnel files of seven staff and found that the provider had completed appropriate checks on them prior to employment. This included obtaining two references from a previous employer to check a prospective employee's experience and skills to carry out the role. The service had systems in place to ensure that all staff received a disclosure and barring service check before starting to work at the service. The staff sickness level for March 2018 was 1.5%.
- A qualified nurse was present in communal areas of the wards at all times. Staffing levels allowed patients to have regular one-to-one time with their named nurse.
- Staff and patients said the wards rarely cancelled patients' escorted leave and activities. Patient records showed that leave had been granted and supported by staff.
- The service had enough staff to carry out physical interventions safely, such as carrying out observations and restraint.

Medical Staff

- The service had adequate medical cover day and night and a doctor could attend the wards in an emergency. Each ward had a permanent ward doctor and a consultant psychiatrist. On Lower Richmond Ward, the consultant psychiatrist attended the ward three days per week.
- A duty doctor and consultant psychiatrist shared responsibility of the duty on call rota.

Mandatory training

- The service provided all staff with mandatory training in key skills required to carry out their role. Overall, 93% of permanent staff had completed their mandatory training. Mandatory training included moving and handling, health and safety, breakaway, first aid awareness and basic life support. Regular agency staff completed the provider's mandatory training. This included breakaway training, which 95% of regular agency staff completed.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff used a risk assessment tool to assess a patient's risk on admission. This tool included several areas of possible risk and had a rating scale to measure the severity of each risk. Records showed there were risk assessments in place for all patients.
- At the last inspection in August 2016, we found that staff had completed risk assessments inconsistently and that staff had not recorded the reasons for changes they made in patient risk scores. At this inspection, we found that no improvement had been made. We reviewed 11 care and treatment records of patients on each ward. Staff rated the severity of risks for some patients differently on separate dates. There was no written explanation of how and why this change had taken place. In the patients' care records, staff recorded discussions about risks at weekly ward rounds and completed the risk inventory form. However, staff did not always record the reasons for any change in risk scores on the risk inventory form as part of the risk assessment. This meant that agency or new staff might not understand what the risks were to the patient and staff if staff had not detailed the level of the risk.
- Six of the 11 patients' care and treatment records showed areas where staff had not adequately assessed the risk in at least one particular risk area for each patient. For example, on Upper Richmond Ward, a patient's records showed that staff assessed them as a risk to children and vulnerable others with a score of 2 (significant risk). It was not recorded why this patient was a risk to children and vulnerable others. This later decreased to a score of 1 for this risk. There was no record next to the score explaining what had changed and why the patient's score for this identified risk had decreased.
- On Lower Richmond Ward, a patient's care and treatment records showed that they had a risk of suicide, which increased from a score of 1 to 2 (significant risk). Staff had not recorded why the patient had been assessed as at risk of suicide in the initial risk assessment and no reason was recorded next to the score explaining why this level of risk had increased. This meant that not all staff, particularly new or agency staff would be aware of the particular details of the potential risks of patients and therefore not be able to address and minimise those risks.

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Management of patient risk

- Patients' risk management plans varied in detail. Staff did not always complete comprehensive risk management plans to safely manage patient risk. For one patient on Lower Richmond Ward, staff had not completed a risk formulation when they had an increased risk of suicide recorded in their risk review. Another patient on Upper Richmond Ward had a risk of violence towards others. Staff had not recorded what factors would reduce their risk of violence and what triggers would contribute to their increase in risk of violence towards others. This meant staff may not identify factors, which could increase or decrease the level of identified risk to safely manage patients.
- Staff used the National Early Warning Score (NEWS) to assess and monitor patients' physical health risks. The provider's policy was to complete daily NEWS on every patient. However, staff did not always follow this policy. For example, on Lower Richmond Ward, staff were required to complete a NEWS chart for one patient every four hours because the patient frequently banged their head. There was no evidence that staff had performed the required checks. Staff calculated each patient's NEWS score each time. We reviewed the NEWS charts for four patients on Lower Richmond Ward and found that the scores for one patient had not been calculated on eight separate occasions. This means that should a patient deteriorate, staff may not take prompt action.
- Staff followed the provider's policy when observing patients or carrying out searches on patients or their property. During our inspection three patients on Lower Richmond Ward, required 1:1 observations and one patient required 3:1 observations. We noted that the required number of staff were with each of the patients in accordance with what we were told by staff.
- Staff searched patients on admission and returning from leave in accordance with the provider's policy. Staff completed training in this area. Staff targeted their searches if there was cause for suspicion.
- Patients did not have access to cups to obtain water and needed to ask a member of staff if they wanted a drink. The communal living areas contained a water cooler machine but no cups to use. We observed on several occasions across the three wards, patients knocking in the staff office door to ask for cups to get a drink of water. We observed patients on Kingston ward cupping water from the water cooler machine in their hands, as they did not have a cup. The hospital manager said that staff kept cups locked away due to the high levels of risk for some patients who could break the cups and use them to injure themselves. However, the service had not sourced other types of cup, which were less of a risk to patients, such as paper cups. The restrictions on access to drinking cups and therefore drinks amounted to a blanket restriction as outlined in the Mental Health Act Code of Practice. The operation of a blanket restriction concerning patient access to cups meant there was an increased risk of patients becoming dehydrated.
- Staff had not implemented a smoke-free policy in the hospital although there were plans to go smoke free by the end of the year. Staff escorted patients out to the garden at set times to smoke.

Use of restrictive interventions

- The service analysed the use of physical restraint. Between November 2017-April 2018, there were 219 episodes of restraint reported by staff at the service, 27 of these incidents of restraint were in the prone position. Most (102) of these restraints took place on Kingston Ward.
- The service had reported no incidents of long-term segregation in the period November 2017-April 2018.
- Staff told us that they used physical restraint only after de-escalation had failed. Staff explained how to safely restrain a patient and to only restrain a patient as a last resort. A patient on Upper Richmond Ward said that they had a positive experience when being restrained. Staff had explained to the patient why physical restraint had been used and how they restrained them. However, this is not what was always observed during the inspection. Sometimes staff did not effectively engage patients when they started to become aggressive or aroused. We observed staff telling patients to 'calm down' when they became agitated rather than using effective de-escalation techniques. We also observed staff using a forearm restraint on several occasions without de-escalating the patient appropriately. A patient on Lower Richmond Ward told us that they did not like the way that staff restrained them as it hurt. This meant that staff might restrain patients in an unsafe and disproportionate way if staff inappropriately de-escalated patients.

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Inadequate

- The service did not yet have a restrictive interventions reduction programme in place. This meant that the service did not have a strategy in place to work on reducing the use of physical restraint and violence and aggression on the wards.
- Staff did not always follow national institute for health and care excellence (NICE) guidelines or the provider's own policy when administering rapid tranquilisation to patients. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. Patients receiving rapid tranquilisation are at risk of seizures, airway obstruction, excessive sedation and cardiac arrest. Therefore, patients need to be monitored closely after they have received rapid tranquilisation medicines. Staff did not consistently take patients' physical health observations following rapid tranquilisation. NICE guidance recommends such observations be taken at least every hour after rapid tranquilisation until there are no more concerns about their physical health status. The providers own policy, provided by the external pharmacist, informed staff to check a patients' vital signs as a minimum every 15 minutes in the first hour, then hourly until the patient is ambulatory.
- Staff did not follow the provider's own policy in relation to recording and monitoring patients' vital signs post rapid tranquilisation. We looked at the records of 35 incidents of rapid tranquilisation administered by injection to 15 patients across all three wards at the hospital and patients' care and treatment records. We found in 24 of the 35 incidents of rapid tranquilisation, the records of the post administration physical health checks showed that the necessary physical health observations had not taken place as required.
- For example, we looked at the rapid tranquilisation form and electronic care records, for a patient on Kingston Ward. Staff had administered rapid tranquilisation twice in the same day. The rapid tranquilisation monitoring form and the patients' electronic care notes showed no record of any physical health observations undertaken by staff in the first hour after the patient received rapid tranquilisation on either of the two occasions. The care and treatment records for another patient on Lower Richmond, showed staff had not recorded on the rapid tranquilisation monitoring form or the patient's electronic care records that staff had carried out any physical health observations on the patient in the first hour after rapid tranquilisation was given.
- We found other records where staff recorded a patient had refused observations in the first 15 minutes after rapid tranquilisation. Staff then had recorded nothing else for the reminder of the first hour or any other physical observations taken such as the patients' respiratory rate or sedation levels. By not carrying out the required physical health observations after the administration of rapid tranquilisation staff did not manage the risk posed to patients after they had received rapid tranquilisation.
- Between November 2017-April 2018, there were 13 incidents of seclusion within the service.
- When staff escorted patients to seclusion, they observed them continuously. Nursing and medical staff reviewed patients at regular intervals. This ensured patients did not remain in seclusion any longer than necessary. For example, we reviewed five patients' seclusion records. These records showed staff observed and carried out medical, nursing and multidisciplinary reviews of patients in seclusion in line with guidance in the Mental Health Act code of practice.
- Staff kept appropriate records of seclusion episodes for patients. Staff kept seclusion records in a paper file and on the patients' electronic care and treatment records.

Safeguarding

- Staff understood how to protect adults and children from abuse. As of March 2018, 86% of staff had completed training in safeguarding vulnerable adults and 90% of staff had completed safeguarding children from abuse training. The lead for safeguarding in the service made referrals and kept records of safeguarding referrals to the local authority safeguarding team. Since December 2017, staff had reported 51 safeguarding concerns to the local authority. Staff could give examples of safeguarding alerts they had made. The majority of examples given by staff were patient on patient violence and aggression.
- Staff told us that out of hours, they telephoned the manager on call for advice and guidance. Staff then informed the hospital safeguarding lead when they returned to work.
- Staff followed safe procedures for children wanting to visit the ward. Staff did not allow children to visit the

wards. The service had a visitor's room located on the ground floor off the ward. If children did visit, they could only use this room accompanied by an adult and prearranged.

Staff access to information

- Staff recorded patient information in two separate systems. Staff used both an electronic and paper copy system to document patient records.
- All staff employed directly by the provider, including permanent and bank staff, had access to the electronic system. Agency staff who did not work at the hospital on a regular basis did not have access to the system, which meant that they were not able to access information directly. This meant agency staff relied on permanent staff to access this information on their behalf.

Medicines management

- Staff did not always follow good practice in medicines management. At the last inspection, we found that staff did not always record the reasons for 'as required' medicines being administered in patients' clinical notes. At this inspection, we found this had not improved. We reviewed four care and treatment records and medicine administration records of patients on Upper Richmond Ward. Staff had administered 'as required' (prn) medicines to patients and staff did not record the reason for administrating the medicines in all four records. For example, the medication administration record of one patient showed that staff administered prn medicines. However, this patient's care and treatment records did not show any reason why staff gave them these medicines.
- We reviewed the medicine administration records for 13 patients across the wards. Staff completed these appropriately. Staff signed when they administered medicines or recorded why not. Staff noted allergies and potential adverse reactions on the patients' records. A pharmacist visited the ward each week. The pharmacist monitored prescriptions and carried out medicine audits.
- The ward doctors completed the medicine reconciliation for newly admitted patients to the ward. We reviewed the reconciliation records for patients recently admitted and found that the doctor had completed these accurately.
- Staff completed appropriate physical health checks on patients who were prescribed high dose antipsychotic medicines. We looked at the medicines administration record for two patients receiving high dose antipsychotic medicine. These showed staff completed investigations such as blood tests and electrocardiograms.

Track record on safety

- The service reported seven serious incidents from May 2017 - April 2018. These took place on December 2017 and January 2018. Staff categorised four of these serious incidents as minor and three no harm or injury.

Reporting incidents and learning from when things go wrong

- Staff did not always report incidents that should be reported. For example, staff did not always report an episode of restraint as an incident. We reviewed the care and treatment records for five patients on Lower Richmond Ward and identified five separate occasions where staff had restrained two patients. Staff had not formally reported this as an incident on two of the five occasions. We found another incident on Upper Richmond Ward, where a patient had been admitted a few days prior to the inspection. The patient had unexplained physical marks. Staff had not recorded this as an incident until we raised it with the ward manager during the inspection. However, staff reported incidents such as patient on patient violence and aggression, patients assaulting staff and security issues.
- Staff did not always receive feedback from investigations of incidents. Our review of ward team meeting minutes and handover records demonstrated that there was no evidence of shared learning from serious incident investigations with staff. However, staff did explain a recent incident that happened and the learning as a result. For example, an incident had occurred with patients using plastic cutlery inappropriately. Since the incident, staff checked and counted the plastic cutlery after each meal to ensure no one removed it from the dining room.
- At the last inspection, we recommended that staff complete debriefing forms in full to ensure learning from incidents took place effectively and staff were supported. At this inspection, we found improvements. The nurse in charge completed a debrief sheet following

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each incident, confirming that discussions had been held with staff involved as well as the patient, a debrief sheet had been completed for most of the incidents we reviewed.

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff understood the need to be open and transparent when things went wrong.

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

- We reviewed 10 patient care and treatment records during our inspection. Staff completed a mental health assessment of patients' needs in a timely manner at, or soon after, admission.
- Staff assessed patients' physical health needs after admission. However, staff did not always address these identified needs in a care plan. For example, we found one patient had a history of seizures, but nurses on shift were unaware of this. Staff had not developed a care plan to ensure adequate seizure management arrangements were in place. We highlighted this to the staff during the inspection and they subsequently addressed this in the patient's care plan. On Kingston Ward, a patient's care and treatment records showed they had physical health needs as they suffered from regular nosebleeds. This patient did not have a care plan in place to address this need.
- At our last inspection in August 2016, we found that care plans were not always personalised and that patients were not always involved in the development of their care plans. During this current inspection, we found no improvement. Nine of the 10 care plans we reviewed lacked detail, were not person centred and were generic. For example, on Lower Richmond Ward, care plans for two different patients had exactly the same goals, "I would like to find alternative ways to manage my anger". Staff had not recorded in care plans what triggered their anger, how they managed their anger or how the patients would like to manage their anger in the future. On Upper Richmond Ward, one patient's care and treatment records stated that they had physical health problems. Staff had not completed a care plan for this patient to address these needs. The same patient's records showed they had autism. This patient did not have a care plan to address their autism needs.
- Patient care plans contained discharge plans. However, these were not always recovery-oriented. For example, on Lower Richmond Ward, two patients' care and treatment records contained no discharge plan. These patients had been at the service for six weeks and three weeks respectively. Another patient's records on Upper Richmond Ward had been at the service since January 2018, approximately four months. A goal in this patient's discharge plan simply stated they would like to gain insight into their illness. This goal was not specific therefore could not effectively support the patient with their journey to discharge or transfer to a less restrictive environment.

Best practice in treatment and care

- The medical team prescribed medicines to treat a patient's condition, which were evidence based according to NICE guidelines and in line with the provider's policy. However, there were occasions when high doses of anti-psychotic medicines outside the usual range were prescribed.
- Patients had access to psychological support. There were two psychologists for the hospital. However, one clinical psychologist was currently on maternity leave and their post had not been covered. Staff informed us that the psychologist attended at least one ward every day and was present at each MDT meetings. Patient records showed that the clinical psychologist either provided input or attempted to provide psychological input to patients on the ward. Psychological support included groups on anger management, self-esteem and relapse prevention. The psychologist also offered one-to-one support to patients such as dialectical behavioural therapy.
- Staff ensured patients had access to physical healthcare. Staff supported patients to attend appointments at other organisations to manage their

physical healthcare needs. For example, on Lower Richmond Ward, we saw that the ward doctor was in the process of liaising with a local trust for one patient to be seen by a neurologist.

- Staff provided some support to patients to live healthier lives. The service had a gym room, which all patients could use to maintain a healthy weight. Staff assessed all patients for their weight and height if the patient consented, and whether they smoked and /or misused substances. However, staff did not put any arrangements in place to encourage patients to give up smoking or refer patients on to smoking cessation services. A staff member had completed a research project on smoking cessation as part of a leadership course and had shared the outcome with colleagues as a way to help prepare them to go smoke free. However, during the inspection, staff did not make nicotine replacement therapy (NRT) available to patients. Although the hospital planned to develop a no smoking policy, which was to be introduced in 2018. Many patients came to the service from an NHS hospital and would probably transfer back to an NHS hospital, where they would not have been able to smoke. Patients may have already been using NRT or other devices to help stop smoking and address their tobacco addiction. The service was not appropriately assessing the needs of the patients and by not offering NRT the service was not meeting the needs of patients who smoked. Following the inspection, the hospital manager provided us with a copy of the provider's new policy on smoking cessation and getting ready to become a smoke-free hospital.
- Staff used recognised rating scales to assess and record severity and outcomes. For example, staff used the Global Assessment of Functioning (GAF) to help predict the allocation and outcomes of mental health treatment.
- At the last inspection in August 2016, we recommended the provider ensure a clear plan was put in place when audits identified a need for improvement. At this inspection, we found no improvements had been made. Staff completed monthly audits for infection control, physical health and care planning and risk assessments. However, these did not identify what actions staff needed to take to address gaps because the findings lacked detail. For example, staff completed an individual risk assessment and care plan audit for 25% of the patients within the service in March 2018. Audit findings reported on the date of the most recent risk assessment or care plan and when it was next due for review. The audits failed to include a review of the content or quality of these documents. This meant staff did not effectively identify and monitor the effectiveness of care and treatment for patients.

Skilled staff to deliver care

- The wards consisted of their own teams with a full range of specialisms required to meet the needs of the patients. These included nursing staff, consultant psychiatrists, and ward doctors. An occupational therapist, a clinical psychologist, activity co-ordinators and an art therapist also supported the wards across the service.
- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Nursing staff and healthcare assistants received support from the psychologist to improve the focus of patient care and consider psychological practices as part of routine care. Occupational therapists offered group and patient specific activities including supporting patients to develop their skills.
- The service provided new staff with a local and corporate induction. The local induction included orientation to the ward and reading various policies and procedures. However, some staff were unaware of ligature anchor points on the wards.
- Managers provided staff with supervision and appraisal of their work performance. The provider's policy required staff to attend supervision every eight weeks. As of March 2018, all staff had received supervision in line with the provider's policy. Supervisors recorded detailed appraisal records for each member of staff appraised.
- The percentage of staff that had an appraisal in the last 12 months was 52%.
- Staff attended regular team meetings taking place on wards. Meeting minutes were stored in a file in the manager's office and staff could access the minutes if they were unable to attend the meeting. The staff meeting did not have a standard agenda or action plan to ensure staff discussed pertinent issues and followed up areas for improvement.
- The hospital provided some specialist training to support staff in their roles. The provider had set up the Huntercombe Academy for staff to attend for courses. For example, some staff had attended a leadership course for nursing staff and some had been trained in

positive behavioural support with the aim of rolling out this approach to all staff. The psychologist provided nursing staff with training in dialectical behavioural therapy to support patients. Staff also completed national vocational qualifications to support them in their roles.

- Managers dealt with poor performance promptly and effectively. Depending on the situation, the manager initially discussed poor performance with the member of staff as part of the supervision process. Managers took appropriate action and followed the hospital's disciplinary policy as required.

Multi-disciplinary and inter-agency team work

- Staff held regular multidisciplinary team meetings. Ward rounds took place three days per week. Staff reviewed each patients' mental and physical health. The service held monthly pharmacy advisory committees, which included the external pharmacist, the hospital manager, ward managers, the consultant psychiatrists and ward doctors.
- Staff shared information about patients at daily handover meetings. The teams had daily handovers between changes in nursing shifts. The handover meetings discussed new admissions, referrals and nursing observations.
- The ward teams had effective working relationships with other teams within the organisation. For example, the provider circulated a monthly quality newsletter for staff to share learning and experiences from the provider's other services.
- The ward teams had effective working relationships with teams outside the organisation. Staff liaised with patients' GPs as well as the referring organisation. Staff also communicated with social services and the patients' care coordinator.

Adherence to the MHA and the MHA Code of Practice

- Staff understood their roles and responsibilities under the Mental Health Act 1983, the Code of Practice and its guiding principles. At the time of this inspection, all patients were detained under the Mental Health Act.
- Training related to applying the Mental Health Act and the Code of Practice was mandatory within the service. At the time of the inspection, 74% of staff had completed training in the Mental Health Act.
- The service had a dedicated Mental Health Act administrator who provided support to staff about the Act and advice on its implementation. Staff completed regular audits to ensure correct application of the Mental Health Act and to identify any concerns promptly. The Mental Health Act administrator completed an audit in March 2018. This audit identified whether section 17 leave paperwork was up-to-date and whether the patient has been appropriately informed of their rights under the Mental Health Act. The administrator also sent a weekly summary to each ward to alert staff when a patient's rights were due to be explained and their section due to expire. Staff knew who their Mental Health Act administrators were.
- Staff had access to the provider's Mental Health Act policies and procedures as well as the Code of Practice, via the intranet.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. We saw evidence of this in each of the patient records we reviewed.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted and this was recorded in their records. Clinicians had clearly recorded the start and end date of patients' leave. Doctors granted patients with leave as part of therapeutic intervention.
- Staff requested an opinion from a second opinion appointed doctor when necessary although this had not been required for each of the patient files we reviewed.
- Detained patients had access to an independent mental health advocate (IMHA) who attended the service weekly.

Good practice in applying the MCA

- The majority of staff had a good understanding of the Mental Capacity Act, and the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care.
- Training for staff in the Mental Capacity Act and deprivation of liberty safeguards (DoLS) was mandatory and all staff had completed the training. The provider supplied staff with a policy on the Mental Capacity Act.
- Records confirmed staff completed patients' consent to treatment and capacity assessments following their admission.
- For patients who might have impaired capacity, staff assessed and recorded capacity to consent appropriately. For example, on Kingston Ward, we saw

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Inadequate

staff completed a capacity assessment, which outlined the decision to be made. The assessment demonstrated that the staff completing it had applied the appropriate test to decide whether a person lacks capacity. This was in line with the Mental Capacity Act Code of Practice.

- When patients lacked capacity, staff made decisions in their best interests. This took account of the persons' culture and history. We saw for a patient on Kingston Ward where the multidisciplinary team had taken into account a patient's best interest when they lacked capacity.

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

Requires improvement

. Kindness, privacy, dignity, respect, compassion and support

- We observed staff and patient interactions throughout the inspection. We saw some minimal interaction between staff and patients. Most staff did not encourage conversations with the patients they were caring for and instead were observing them to ensure the patient remained safe. On Upper Richmond and Lower Richmond wards, we saw staff watching TV with a patient and not engaging them in conversation. On the first day of the inspection, we did not observe any activities taking place on Upper Richmond Ward. However, we did observe some positive interactions between staff and patients. For example, on Kingston Ward, we observed staff and patients enjoying a game of table tennis together. On Upper Richmond, we observed a patient reading with staff whilst on their one-to-one nursing observations.
- We spoke with 11 patients. The patients gave us mixed feedback about whether staff treated them with compassion, respect and kindness. Five patients said that staff were not always caring and polite towards them. One patient said that staff spoke to each other in their own language in front of them and the patient could not understand what they said. Another patient said that staff did not occupy them on the wards. Four patients were more positive and said that staff treated them with respect and tried to help them. These patients said they felt safe on the wards. Most patients said staff knocked on the door before entering their bedrooms. Staff, as well as agency staff, could demonstrate knowledge and understanding of people's needs and were able to tell us about the circumstances of their admission.
- We also observed areas on the ward that did not maintain patients' privacy and dignity. Each bathroom had a small glass panel on the door for staff to observe patients in the bathrooms. Staff and patients could cover these panels to maintain privacy. However, on Upper Richmond Ward we found that all of the covers were placed down (open) and three of the seven bathroom doors' covers were broken. Therefore, patients could not cover them when they needed privacy in the bathroom. This meant that any person walking past the bathroom door could peer in. This did not promote privacy for the patients. We highlighted this to the hospital manager, who said they would address the issue as soon as possible.
- Staff completed patient led assessments of the care environment (PLACE). Patients scored 94% for privacy, dignity and wellbeing at the service in the most recent PLACE assessment.
- Staff maintained the confidentiality of information about patients. Staff discussed patients' care in private and recorded this in paper files that they kept locked away or stored electronically with a password protection.

Involvement in Care

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward and to the service. Patients received an information booklet on admission.
- Staff did not always involve patients in their care planning and risk assessments. Three of the four patients we spoke with about involvement in care planning told us they had not received a copy of their care plan. Another patient told us they had a copy of their care plan but was not involved in creating the care plan. The two care and treatment records we reviewed on Upper Richmond Ward, showed no patient involvement. Another two patients, on Kingston Ward, had the same statements recorded in the patient voice.
- Staff supported patients to understand and manage their care and treatment. Staff involved patients in their

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Inadequate

ward rounds. Staff invited patients to attend their ward round and discuss their thoughts on their care and treatment. Staff informed us that where patients were not able to attend the multidisciplinary discussion they had a one-to-one discussion with them outside of the ward round. However, on Lower Richmond Ward, leaflets providing information to patients on their mental health conditions were not readily available. The nurse in charge said they would be made available on request but they were not sure what leaflets were available.

- Staff enabled patients to give feedback about the service. Staff held community meetings with patients once a fortnight on each ward. However, these meetings did not have a set agenda or record of actions implemented in response to patient feedback. The service also conducted an annual patient survey for patients to feedback about the quality of care they received in March 2018. Twenty-two patients responded and staff had analysed the results. A comment box was in the main communal areas of each ward. The wards had a 'you said, we did' board and staff placed patient requests on the board. However, the responses or action taken in response to all this feedback was not clearly described or fed back to the patients.
- Staff displayed the contact details of the local advocacy services providing both statutory and non-statutory advocacy. The advocate attended the service regularly and supported patients to complain and speak up to have their voices heard.

Involvement of families and carers

- Staff did not always invite families and carers to attend multidisciplinary meetings to review patient's individual progress. The provider said this was for practical reasons. Families could provide feedback to staff by arranging a specific time to meet with the doctor or nursing staff outside of these meetings. This did not promote family involvement. Staff provided families and carers with an information leaflet, containing contact numbers for the wards and visiting arrangements.
- The hospital provided an annual survey for patients and carers. We looked at the survey for March 2018 and found that no carers had responded. Family and carers could provide feedback formally. We saw several complaints submitted by relatives. These were about staff treatment of their loved one on the wards.
- Often families and carers lived long distances away from their loved ones. Families and carers could contact the service to speak about their relative at any time if they wished to do so. We observed family and friends ringing the service throughout the day to speak to their loved one, which staff facilitated.

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

(for example, to feedback?)

Good

Access and discharge

Bed Management

- The service's average bed occupancy over the last 12 months was 23.7%. However, at the time of the inspection the service only had one vacant bed. The service had 11 patients who were from outside of the London area at the time of the inspection. The service received referrals for psychiatric intensive care beds from across the country. Referrals also came from local NHS trusts where they needed the extra beds. One local NHS trust had two contracted female PICU beds at the hospital at the time of the inspection.
- Until recently, Lower Richmond Ward was a PICU ward. It had recently changed to become a complex care ward. The aim was for patients with complex mental health needs to be supported over a longer period. Then patients would be rehabilitated to live in the community. The ward accepted admissions of female patients only. Since the transformation of the ward, staff had admitted one patient in accordance with the new criteria. All other patients had been admitted as an acute patient stepped down from Upper Richmond Ward.
- Patients only moved between the wards on clinical grounds. For example, a patient on Upper Richmond moved to Lower Richmond as their needs had changed.
- When patients were moved or discharged, this happened at an appropriate time of day. Staff ensured that when they transferred or discharged patients that this was always before 8pm.

Discharge and transfers of care

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Inadequate

- Staff planned for patients' discharge, including liaison with the patient's home NHS trust as well as their funding authority and the patients' care co-ordinator. On Lower Richmond Ward, the service's step down ward, staff did not have a formal system in place to ensure patients had established rehabilitation goals to prepare for discharge. The service aimed to care for patients, on Lower Richmond Ward, under the new care pathway for between three and six months. The new care pathway suggested that patients' discharge plan would start on admission. However, we did not see evidence of this on the complex care patient's file.
- Staff did not delay a patient's discharge for any reason other than on clinical grounds. At the time of the inspection, there were no delayed discharges.
- Staff supported patients during referrals and transfers between services. However, this was usually when the patients were ready for discharge to a step down service or acute bed.

Facilities that promote comfort, dignity and privacy

- Patients had their own bedroom. Patients could personalise their bedroom with posters and photos if they wanted to although none of the patients had done so. Patients shared bathrooms on each ward.
- Patients had somewhere to store their possessions. Patients had safes in their rooms to store possessions and could request that staff lock their bedroom doors when they temporarily left the ward.
- Staff and patients had access to a full range of rooms and equipment to meet their needs. Each ward had a communal dining room, living space and bathrooms. Each ward had an activity room. Each ward had a dedicated clinic room, with enough space for patients to have a physical examination.
- The wards had a quiet area for patients to meet their visitors. For Lower Richmond Ward, the visitors' space was off the ward.
- Patients could make a phone call in private. Some patients could use personal mobile phones on the wards. These were basic phones without a camera, to protect patients' privacy whilst on the wards. Staff had assessed some patients for access to their mobile phone. Patients could also access the ward phone to make private conversations if they wished to do so.
- Patients had access to outside space. Patients on Upper Richmond and Kingston Wards had to be escorted downstairs to use the garden. Lower Richmond Ward had direct access to the shared garden where patients could play games.
- Patients did not have access to hot drinks, but could ask staff if they wanted one. However, one patient said they waited eight hours to get a hot drink. Patients experienced delays obtaining a drink of water because they had to knock on the staff office door to get a cup so that they could use the communal water cooler.
- Patients had a choice of meals. The meal menu offered a choice of meat and non-meat dishes. The chef catered for patients who required special diets for health or religious reasons. Patients told us staff met their dietary needs. Staff supported patients who needed diets for their lactose intolerance, diabetic needs and vegetarian needs. The PLACE survey score for food on the wards was 95%.
- Patients had access to a range of activities in the shared activities room, which included table tennis and board games, artwork, the gym and occupational therapy activities. Patients had access to activities and groups. There was a timetable for each ward, which displayed the days and times of each group. There were two hours of activities available on Tuesday, Wednesday and Friday and 45 minutes offered on a Monday and a Wednesday. The timetable did not include activities at weekends. The patient survey in 2018 showed that only 30% of patients who responded were happy with the amount of activities available. Two patients commented on the lack of activities at the weekends and that there was nothing to do. The Kingston clinical improvement group meeting on 24 April 2018 showed that the ward manager was going to meet with the occupational therapist (OT) to discuss activities at the weekend due to patients being bored. The OT department still needed to recruit an activities coordinator to support the wards.

Patients' engagement with the wider community

- Staff did not support patients with education and work opportunities. At the time of the inspection, patients were not involved in engaging in any work experience of educational courses. Patients only stayed at the service for short amounts of time.
- Staff supported patients to maintain contact with their families and carers. Staff supported the families and

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

Inadequate

carers of patients to visit them, but often relatives had to travel long distances. Where patients' relatives could not travel the distance, staff supported patients to speak to them over the telephone.

Meeting the needs of all people who use the service

- The service made adjustments for disabled patients. The service had a lift to gain access to the two wards on the first floor. Lower Richmond Ward was on the ground floor and people with mobility difficulties could access the ward easily. Patients with reduced mobility were assessed on an individual basis and offered admission if staff could meet their needs.
- Staff spoke about what support they would give LGBT+ patients and support to patients around their sexuality. For example, the provider had a policy on relationships and sexuality. This highlighted the need for staff to treat patients regardless of their sexuality and sexual orientation with privacy, dignity and respect. However, staff said that they have supported transgender patients in the past but not currently.
- There was a range of information available to patients on each of the wards. Information was available on local services, advocacy and complaints. However, on Lower Richmond Ward we noted that the provider had not updated the leaflet to reflect the recent changes to the service. Staff did not provide the information leaflet in easy read for patients. Therefore, the leaflet may be difficult to understand for some patients, and it did not include information about their rights.
- Staff provided information in the English language. However, for patients whose first language was not English staff would provide interpreters or source information available in other languages.
- Staff ensured patients had access to spiritual support. Staff displayed information about spiritual support and informed patients where they could access facilities to pray. There was dedicated space on the ground floor where patients could pray if they wished to do so.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously and investigated them. The service received 10 complaints from May 2017- March 2018. The complaints involved delivery of treatment or inappropriate behaviour from staff. None of the complaints were upheld by the service. None of the complainants had been escalated further.
- Patients knew how to complain and felt able to do so. Patients' information packs contained the information about the complaints process and staff displayed it on the noticeboards.
- When patients complained, staff ensured they provided them with feedback.
- Whilst staff kept a complaint learning outcome on their complaints log, lessons learnt as a result were not always circulated amongst staff. The administration staff kept a log of all complaints, formal and informal, received about the service, which contained a learning outcome. This meant that managers and staff could keep track of complaints about the service and identify themes. However, staff meeting minutes did not include any feedback from learning from patient complaints. The clinical improvement group (CIG) minutes for each ward included complaints as a standard agenda item. The minutes from the February and March CIG meetings stated that had been no complaints for the service. The complaints log showed complaints were received in February 2018 and March 2018 respectively. This meant that complaints were not always discussed amongst staff and lessons learnt as a result.

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

Inadequate

Leadership

- The leadership of the service was not of the quality required to provide safe and effective care for patients with complex needs. We noted that two of the three ward managers had limited knowledge of the patients admitted to the wards and about current patient risks. The ward managers on Upper and Lower Richmond wards could not tell us what the risks to patients were and where to find some pertinent information relevant to the operation of the ward. They did not know for example, how to escalate risks about the service and how to ensure these were on the hospital risk register.

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

Inadequate

- Leaders were approachable for patients and staff. The local senior management team consisted of the hospital manager and the regional service manager. Staff knew who the local senior management team were and commented that the hospital manager often attended the ward. However, some staff commented that senior management within the organisation did not often visit the wards.
- Leadership development opportunities were available, including opportunities for staff below ward manager level. The service had recently established an academy and the provider supported staff to undertake learning and development to support their career progression.

Vision and strategy

- Staff did not know the provider's vision and values. The provider's values included putting the person first, innovation, understanding, excellence, reliable and accessible. Staff told us that they treated patients with respect, compassion and treated every patient as an individual. However, we did not observe this at all times during the inspection.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For example, the service was due to go smoke-free soon. A staff member had completed a research project on smoking cessation as part of a leadership course and had shared the outcome with colleagues as a way to help prepare them to go smoke free.
- The hospital manager could explain how they were working to deliver high quality care within the budgets available. For example, deploying extra healthcare assistants to meet the changing needs of the patients.

Culture

- Staff felt respected, supported, valued and proud about working within their teams. The provider conducted a staff survey in 2018. From this, only 28% (33) of staff responded. We looked at the results of the survey. From those who responded, 96% of staff felt their work was valued.
- Staff felt comfortable to raise concerns with their manager and felt listened to. From the staff survey 2018, 83% of staff felt able to raise concerns and that managers would listen to them. Staff knew how to use the whistle blowing process and information, including contact details displayed on notice boards. Staff said they could raise concerns about disrespectful or abusive behaviour towards patients. The staff survey showed 89% of staff could report unsafe clinical practice towards a patient.
- Staff spoke positively about opportunities for professional development. There were development opportunities available for both qualified and unqualified staff. From the staff survey 2018, 70% of staff had a conversation with their line manager about their professional development.
- Managers dealt with poor performance when needed. Depending on the circumstances, managers addressed poor performance by discussing areas for improvement through supervision. If necessary, managers followed the hospital's disciplinary process and could contact the human resources department for advice if they needed to.
- The teams worked well together, and where there were difficulties managers dealt with them appropriately.
- Staff appraisals included conversations about career progression where relevant. We reviewed a sample of staff appraisals during our inspection. Managers discussed career pathways with staff and how they could support their development. However, only 52% had received an annual appraisal over the last 12 months. Staff sickness was low. For April 2018, it was 1.5%.
- Staff knew they could access support for their own physical and emotional health needs through the provider's occupational health service.

Governance

- The hospital did not have a clear system or framework for the discussion of important information such as learning from incidents, complaints, audits and alerts. Each ward held regular staff meetings. Staff discussed a range of topics, such as staffing or general housekeeping but did not routinely use the opportunity to learn and discuss improvements. Staff meeting minutes did not contain a standard agenda that staff could follow to ensure these important issues were discussed. Patient community meeting minutes did not show that staff followed up any areas identified for improvement. For example, on Upper Richmond Ward three consecutive meetings between March and April 2018 showed that patients had raised concerns about not having access to cups to get a drink. The ward managers and hospital manager met every day to

discuss issues on the wards like staffing, referrals, incidents and safeguarding in the operations meetings. We looked at these minutes for March 2018. Whilst this had a standard agenda containing action points and the person responsible, this was not completed. This meant that areas identified for improvement would not be followed up.

- Due to the complex needs of the patients, the hospital was regularly using rapid tranquilisation and high dose antipsychotic therapy (HDAT). The service was not able to analyse the frequency that rapid tranquilisation was administered to patients within the service. Without an overview of the use of rapid tranquilisation, there was a risk that patients would be put at risk of avoidable harm. The pharmacist kept their own audits on patients receiving HDAT. We looked at the minutes of the Pharmacy Advisory Committee from January-April 2018. These showed that staff discussed medicines errors, but not the patients receiving HDAT or the number of people receiving rapid tranquilisation across the service. This meant that managers might not have oversight of important information in relation to patient safety. Therefore, the provider did not adequately monitor and mitigate the risks to patients.
- Staff had not addressed requirements and recommendations resulting from past CQC inspections. For example, we looked at the provider's CQC action plan addressing concerns about staff member's failing to record why they had administered 'as required' (prn) medicines in patients' clinical notes from the August 2016 inspection. Staff updated this action plan in March 2018. This action plan showed the target date for completion of this improvement was 'ongoing'. Another action plan addressing the concerns identified in respect of care planning from the August 2016 inspection showed the target date for completion for this action plan was 'ongoing'. The plan did not contain a specific deadline. This meant the provider could not be assured that it would be completed within a reasonable timeframe and the quality of care plans were not effectively monitored and improved.
- At the last inspection, we recommended that the provider ensure clear action plans to address shortfalls identified by audits were in place. At this inspection, we found no improvements had been made. Action plans addressing gaps identified in audits had no specific timescales for when staff needed to complete actions by. Staff completed audits using a standard provider audit template. For example, we looked at a copy of the 'physical health and early warning sign audit' dated 13 March 2018. This audit was on the provider's audit template, and was a sample of 25% of the patients in the hospital. One audit criteria was 'service users are physically monitored according to best practice following administration of PRN ('as required') and RT (rapid tranquilisation) medication and this is documented within their medical record.' Staff had rated this section 'good'. The audit did not recorded whether staff had undertaken physical health checks at the recommended frequency after rapid tranquilisation had been administered. Where staff had rated an audit criteria as 'requires improvement', for example the 'relevant National Early Warning Score charts being used correctly', these did not have any follow up actions as a result. This meant the systems in place did not effectively ensure that risk to patients were assessed, monitored or reduced.

Management of risk, issues and performance

- The hospital manager maintained a risk register. The hospital manager updated the register to include staffing and financial risks such as a decrease in bed occupancy. Staff had action points and timeframes to work towards reducing this risk. Staff rated each risk red, amber or green depending on the level of risk. However, the risks on the register did not include the concerns found at this inspection, such as the risk of failing to complete the requirement notices from the last CQC inspection, and other risks which could have an adverse impact on patient care.
- The service had a business contingency plan in place to support staff in case of emergencies for example, an epidemic or adverse weather conditions.

Information management

- The service used systems to collect data about the performance of the wards. These systems were not over burdensome for frontline staff. However, this data was not always accurate, for example as all incidents of restraint were not reported.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. For example, most patient records were stored electronically so staff notes on patient care and safety

could be clearly read, rather than being handwritten. Staff could receive rapid access to blood test results via fax. Staff employed directly by the provider, including permanent, bank and long-term agency staff had access to the electronic system.

- Information governance systems stored patient records confidentially. Patient identifiable information was not on display in public areas.
- Team managers did not always have access to information to support them with their management role. For example, two ward managers told us they did not know about their local risk register and how to add risks they found to it. The service had a quality dashboard that contained the number of incidents at a glance. The daily operations meetings meant that ward managers met with the hospital manager every day to discuss staffing, referrals, incidents and patient observation levels. The Mental Health Act administrator supported ward managers to ensure that all Mental Health Act paperwork was up to date.
- Staff made notifications to external bodies as needed and we saw examples of incidents reported to the commissioner. The service informed the Care Quality Commission of notifiable incidents, including incidents involving the police.

Engagement

- Staff had access to up-to-date information about the work of the provider. This was through the staff intranet, bulletins and quality newsletters. The April 2018 quality newsletter detailed what was going on within the organisation. For example, the newsletter contained information about patient safety incidents and learning outcomes at another of the provider's hospitals. Carers could access the provider's website to find out further information on the service. Noticeboards on the wards supplied information to the patients.
- Whilst there were systems in place for relatives and carers to provide feedback about the service these were clearly not effective. A poster in the main reception of the hospital gave visitors information about completing a friends and family test on the hospitals electronic tablet device. However, there was no feedback from this.
- The clinical improvement group meeting had patient feedback as a standard agenda item. Staff also said that patient representatives could attend the CIG meetings. However, the minutes for Kingston Ward CIG between January - Mach 2018 showed that a patient representative did not attend and therefore staff did not discuss patient feedback.
- Whilst systems were in place to enable staff to provide feedback through a staff survey only 28% of staff completed the survey. This was a low response rate. Further work was needed to support staff to provide feedback.
- Patients and staff could meet with members of the providers' senior leadership team and give feedback. The hospital manager regularly attended the wards and facilitated meetings to meet patients.
- Senior managers engaged with some external stakeholders. These included commissioners and care coordinators.

Commitment to quality improvement and innovation

- The service had not yet received accreditation for inpatients mental health services (AIMS) for psychiatric intensive care units. At the time of the inspection, the service had been reviewed and was awaiting the outcome.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff record the reasons why a patient's risk level has changed. Staff must ensure that where a risk assessment score changes, the reason for this is recorded in patient notes. Staff must clearly record the risks posed to patients and how this is managed.
- The provider must ensure staff monitor and record patients' physical health vital signs after the patient has received rapid tranquilisation. This must be recorded in line with the provider's policy of every 15 minutes for the first hour and then every hour until the patient is ambulatory.
- The provider must ensure that staff record the reason why they have administered 'as required' medicines for patients.
- The provider must ensure they provide sufficient quantities of cups for patients to get themselves a drink of water from the communal water cooler.
- The provider must ensure staff complete care plans with patients to reflect their individual needs and preferences. Care plans must be personalised.
- The provider must ensure a clear framework of what must be discussed at a ward and team level in team meetings to ensure that essential information is shared with staff.
- The provider must ensure they accurately analyse and monitor the use of rapid tranquilisation and high dose antipsychotic therapy to keep patients safe
- The provider must ensure that audits are of good quality. Where shortfalls or gaps are identified a clear time limited action plan with named people responsible for implementation is in place and monitored.
- The provider must ensure that systems in place to assess, monitor and improve the quality of service are effective. Staff must ensure that requirements and recommendations from the past two CQC inspections are fully implemented and improved upon.
- The provider must ensure the risk register reflects pertinent risks to the service, such as lack of physical health monitoring post rapid tranquilisation and staff complete risk assessments to reduce the risk to patients and staff. Ward managers must know about the local risk register and escalate concerns of the wards onto it.
- The provider must ensure they protect the privacy and dignity of patients in the bathrooms, especially on Upper Richmond Ward. The screens on the bathroom door spyholes must be fixed so patients and staff can cover the spyholes and only use them when indicated in terms of risk.
- The provider must ensure staff are encouraged to interact with patients in a positive, caring and compassionate way. Staff must ensure they engage patients when on one-to-one nursing observations
- The provider must ensure that staff that carry out physical health checks on patients do so on a daily basis, as stipulated in the provider's policy. Staff must ensure they understand when they need to escalate concerns.
- The provider must ensure that staff support patients to stop smoking. Patients must be provided with smoking cessation support ready for the hospital becoming smoke free.
- The provider must ensure they update the wards' ligature risk assessments to include all ligature points on the wards. The provider must ensure staff are aware of the ligature points on each ward and how to mitigate the risks.
- The provider must ensure that staff record all incidents onto the electronic reporting systems and that learning from incidents routinely takes place by ward teams.

Action the provider SHOULD take to improve

- The provider should continue to provide training to all staff in positive behaviour support and care planning to support patients.
- The provider should ensure staff use correct techniques to de-escalate patients who are aggressive or aroused.
- The provider should ensure the service participates in a reducing restrictive practices programme to help reduce violence and aggression on the wards.

Outstanding practice and areas for improvement

- The provider should continue to ensure they recruit permanent staff.
- The provider should ensure activities for patients are provided at the weekend.
- The provider should ensure patients are involved in developing their own care plan.
- The provider should ensure that equipment used for clinical examinations is kept clean.
- The provider should ensure complaints are discussed in staff meetings and clinical improvement meetings to ensure learning is shared amongst staff to improve the service.
- The provider should encourage staff to complete the annual staff survey to ensure that all staff have a chance to feedback about the service.
- The provider should ensure that where patients have given feedback that the actions take place and that they are given feedback on the progress.
- The provider should ensure that relatives and carers are supported to provide feedback about the service.

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 Bathroom doors, especially on Upper Richmond did not promote privacy for patients. Communal bathrooms had spyholes, which were not covered and some could not be closed. This meant patients and staff walking past could see in. Staff did not always interact with patients in a positive, compassionate and caring way whilst on one-to-one nursing observations. This was a breach of regulation 10 (1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have a clear framework of what must be discussed at a ward and team level in team meetings to ensure that essential information is shared with staff. Team meetings and community meetings had no standard agenda or clear action plans to follow up any concerns or issues highlighted during these meetings. Audits had no clear plans for staff to follow up when improvements were identified. The provider had not taken action to address all concerns from the August 2016 inspection. The service risk register did not contain all pertinent areas if risk. Not all ward managers knew what the risk register was or where it was stored. This was a breach of Regulation 17(1)(2)(a)(b)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not record patient's physical health observations in line with the provider's policy. The ligature risk assessment did not contain all ligature risk and some staff were not aware of all ligature points. Staff did not report all incidents to the electronic reporting system. We found a few incidents of restraint that had not been reported as an incident. This was a breach of Regulation 12 (1)(2) (a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Staff did not assess and provide patients with smoking cessation support to help quit smoking for when the service becomes smoke free. This was a breach of Regulation 9 (1)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not do all that was reasonably practicable to mitigate the risks to patients receiving rapid tranquilisation. The provider did not carry out the proper and safe management of medicines. The provider did not adequately assess the risks to the health and safety of service users of receiving the care or treatment; and did not mitigate these risks. The provider did not provide sufficient drinking cups to ensure the safety of service users and meet their needs. The communal living areas contained a water cooler machine. There were no cups available in the communal area for patients to use to get themselves a drink of water. Patients needed to approach staff or knock on the staff office door to ask for a cup every time they wanted a drink. This put patients at risk of serious dehydration. This was a breach of regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not ensure care and treatment of service users met their needs and reflected their preferences. The provider did not effectively carry out collaborative care plans designed with a view to achieving service users' preferences and ensuring their needs were met

This section is primarily information for the provider

Enforcement actions

This was a breach of regulation 9(1)(b)(c)(3)(b)