Butterworth Centre

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

Following this inspection, we rated wards for older people with mental health problems at Butterworth Centre as **requires improvement** because:

- The environment needed work to ensure it was dementia friendly and to minimise disorientation of patients who lived with organic mental health conditions including advanced dementia.
- Whilst overall, the provider maintained safe staffing levels, qualified nurses were under pressure as a result of their workloads. One qualified nurse was employed on each ward at all times, but they were often away from the ward attending meetings elsewhere in the building.
- The provider did not ensure all staff completed mandatory training. In most areas less than 75% of staff had completed mandatory training. Whilst uptake of mandatory moving and transferring training was improving, we saw some instances of patients being poorly support with moving and transferring during the inspection. The provider took immediate action to provide additional training and support to staff in this area.
- The hospital did not meet the requirements of the Department of Health same sex accommodation guidance, meaning that the privacy and dignity of patients could have been compromised. Patient bedrooms were situated on mixed corridors and the service did not provide a female only lounge.
- Whilst the provider had systems in place to protect patients from abuse, staff understanding of their responsibilities with regards to safeguarding was variable and take up of mandatory training in relation to safeguarding was low at 50%.
- A small number of incidents that should have been reported, had not been reported. For one patient at risk of being restrained when supported with their personal care an incident report each time this occurred had not been completed in line with the providers policy and procedure. Whilst learning and improvement as a result of incidents was taking place, a system to routinely share this learning with all staff was not embedded.
- Staff did not receive regular one to one supervision sessions. Supervision took place for some staff sporadically. On occasions where supervision sessions had taken place, clinical discussions were not held.
- Some medical equipment, on the ground floor, used to monitor patients' physical health had not been calibrated.
- Although group activities took place, there was a lack of person-centred, one to one activities to develop individual interests and promote recovery and wellbeing.

However,

- A carers' group had recently been set up. Carers told us they were well informed and involved in their relative's care, and had the opportunity to feed back about the service at the carers' group.
- The environment was clean, well maintained and there were different areas for activities to take place. All patients had access to lockable spaces to keep their possessions safe.
- Patients and carers were involved in care planning. They had contributed to detailed 'about me' sections. Permanent staff showed that they knew and understood the patients they cared for.
- Patients had good access to advocacy. Staff referred patients to the advocate. The advocate also introduced themselves to patients and could be approached directly.
- Physical health care provisions were in place. Ongoing physical health monitoring was detailed and physical health checks took place annually for all patients. A physical health lead nurse worked at the service three days per week and a general practitioner also visited twice per week. Physical health needs were discussed in detail during ward rounds.
- Regular ward rounds involving doctors and nurses and nursing handovers took place. Notes were included in patient care records and were up to date.

Summary of findings

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Requires improvement

Butterworth Centre

Services we looked at

Wards for older people with mental health problems

Summary of this inspection

Background to Butterworth Centre

Butterworth Centre provides continuing care for up to 42 patients over the age of 65 from the City of Westminster who are living with mental health conditions.

The provider, Sanctuary Care Limited, acquired Butterworth Centre in August 2016 from the former provider. A registered manager is in post and the service is registered to provide the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983, diagnostic and screening procedures, and treatment of disease, disorder or injury.

The service is made up of three mixed-sex wards on three floors. The majority of patients receiving care and treatment at Butterworth Centre are living with organic mental health conditions such as advanced dementia. Many of the patients are living with long term physical health conditions and have mobility issues. The service provides end of life care for some patients.

Our inspection team

The inspection team consisted of five CQC inspectors, a CQC pharmacist specialist, an expert by experience and three specialist advisors with backgrounds in psychiatry, nursing and Mental Health Act law.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

We last inspected this service under the previous provider in February 2015 but this is the first time that we have inspected this hospital under the current provider.

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 visiting we reviewed a range of information we hold about the provider and asked stakeholders including commissioners and the advocacy service to share what they knew.

During the visit, the inspection team:

- visited all three wards and observed the quality of the environment and how staff were caring for the patients
- completed a short observational framework for investigation (SOFI), an enhanced observation of staff and patient interactions, on the second floor

Summary of this inspection

- looked at 23 care and treatment records for patients, including care plans and risk assessments
- looked at 13 prescription charts
- spoke with two patients and five relatives of patients who used the service about their experience
- spoke with the hospital manager, deputy hospital manager and nurse in charge for each of the three wards
- spoke with the regional director and director of care for the organisation
- spoke with the clinical medical director
- observed an multi-disciplinary team review meeting
- observed a quality improvement meeting
- observed a community meeting
- carried out specific checks on each of the three clinic rooms, medication storage and management and emergency equipment
- collected feedback about the service from the visiting GP
- reviewed a range of meeting minutes, policies and procedures relating to the running of the service.
- reviewed seven incident records
- reviewed six individual staff supervision records.

What people who use the service say

We spoke with two patients and five carers during our inspection. Most patients had complex mental and physical health needs and were unable to tell us their experiences. We therefore used different methods, including observation to help us understand their experiences.

The patients and relatives we did speak to were very positive about the staff, saying they treated them with dignity and respect. Relatives told us that staff kept them informed about developments to patient's care, and felt they were able to approach staff for help and advice easily.

Relatives told us they found the new carers' support group particularly useful, and felt that it gave them the opportunity to feed back about the service and meet other carers for peer support.

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?

Requires improvement 

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

- The hospital did not meet the requirements of the same sex accommodation guidance. This meant the privacy and dignity of some patients was compromised.
- Whilst overall, the provider maintained safe staffing levels, qualified nurses were under pressure as a result of their workloads. One qualified nurse was employed on each ward at all times, but they were often away from the ward attending meetings elsewhere in the building.
- The provider did not ensure all staff completed mandatory training. In most areas less than 75% of staff had completed mandatory training. Whilst uptake of mandatory moving and transferring training was improving, we saw some instances of patients being poorly support with moving and transferring during the inspection. The provider took immediate action to provide additional training and support to staff in this area.
- Six out of the 23 risk assessments we reviewed had not been updated to reflect current risks and the plans to manage them. However, observations of and discussions with staff, demonstrated a sound understanding of patients needs, associate risks and the measure to mitigate these.
- Whilst the provider had systems in place to protect patients from abuse, staff understanding of their responsibilities with regards to safeguarding was variable and take up of mandatory training in relation to safeguarding was low at 50%.
- A small number of incidents that should have been reported, had not been reported. For one patient at risk of being restrained when supported with their personal care an incident report each time this occurred had not been completed in line with the providers policy and procedure. Whilst learning and improvement as a result of incidents was taking place, a system to routinely share this learning with all staff was not embedded.
- Some medical equipment used to monitor patients' physical health on the ground floor had not been calibrated.

However,

Summary of this inspection

- The environment was clean and well maintained. Staff observed infection prevention control principles and maintenance issues were addressed promptly.
- The provider safely managed medicines. Prescription charts were correctly filled in and screened regularly by the pharmacist.
- The provider had recruited some permanent staff to vacancies and planned to fill remaining vacant posts within two months of the inspection. The provider used regular agency staff to cover vacant posts.
- Staff effectively managed pressure care to reduce the risk of patients developing pressure sores and equipment was used to minimise harm caused by falls, such as low profile beds and crash mats.

Are services effective?

Requires improvement

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

- Some care plans lacked detail, and we found key information such as special diets were not reflected in care plans. New staff and agency staff members were therefore put at risk of not being able to deliver appropriate care to individuals.
- The provider had encountered challenges in access to treatments and therapies from all relevant professional disciplines, such as speech and language therapists, dieticians, occupational therapists and physiotherapists, because of the way that these services were commissioned. The provider had escalated challenges in accessing these services with commissioners and had decided to access these services privately when they could not be accessed via the commissioned pathway.
- We identified three occasions when staff did not complete national early warning sign (NEWS) scores to record physical health observations.
- We identified three occasions when staff did not always correctly calculate malnutrition universal screening tool (MUST) scores to ensure patients received the right nutrition.
- Staff did not receive regular one to one supervision sessions. Supervision took place for some staff sporadically. On occasions where supervision sessions had taken place, clinical discussions were not held.
- Only 48% of staff had received an appraisal in the last 12 months.

Summary of this inspection

- Although introductory level training in the MHA was given to staff, some staff did not have a good understanding of the Mental Health Act (MHA), the code of practice and the guiding principles.

However,

- Ongoing physical health monitoring took place and was detailed in care records. Detailed physical health checks took place annually for all patients and a physical health lead nurse worked at the service three days per week.
- Care plans contained detailed information about patients' backgrounds and were updated regularly.
- New staff and agency staff were given an induction during their first shift, which included information about each patient they would be caring for.
- Regular ward rounds with doctors and nurses and nursing handovers took place. Notes were included in patient care records and were up to date.

Are services caring?

Good

We rated **caring** as **good** because:

- The provider had recently introduced a carers' group. Carers who we spoke with were very positive about the support that this group gave them, and that they could provide feedback about the service.
- Patients and relatives who we spoke with were very positive about staff. Permanent staff who had been working at the service for a while showed a clear understanding of individual patient needs.
- Patients had good access to advocacy. Staff readily referred patients to the advocate and the advocate made themselves known to patients when they visited the hospital so that patients could approach them if they wanted to.
- Patients and carers were involved in care planning, and had contributed to 'about me' sections in patient care records.

However,

- We found that quality of staff interactions with patients varied across the hospital. On the second floor most interactions between staff and patients were task oriented.

Summary of this inspection

- Daily community meetings were held for patients on each floor but were used by staff to discuss their duties for the day and did not fully involve patients in discussing feedback about the hospital.

Are services responsive?

Good

We rated **responsive** as **good** because:

- The building provided a large bright space with a good range of facilities. Various rooms were available for activities or to use as a quiet space. A large multi-purpose room was available on the top floor. A hairdressing salon and a room which carers could use for overnight stays were also available.
- Patients could store their possessions securely in lockable cabinets and bedrooms could be locked by staff if patients wanted their room locked.
- A clear set of admission criteria was being developed to ensure patients' needs would be best met in a hospital environment. Many existing patients had been offered a bed for life under the previous provider, and may have been better suited to nursing or care home environments.

However;

- The environment was not dementia friendly. There was a lack of dementia friendly signage, pictures and contrasting colours to help patients orientate themselves.
- Meal times were task oriented and slow. Staff did not engage with all patients. Hot food was served after prolonged periods of time, and in some cases was cold before patients received it.
- Activities were not individualised and patients did not have personal activity plans in place to help promote their recovery and wellbeing.

Are services well-led?

Good

We rated **well led** as **good** because:

- Staff told us that they worked well as a team and could easily approach their peers or managers for advice without fear of blame or victimisation. Senior managers in the organisation visited the hospital and staff could approach them.
- Staff robustly monitored the use of the Mental Capacity Act (MCA). Staff could easily see when Deprivation of Liberty Safeguards (DoLS) authorisations needed to be renewed and were able to chase pending DoLS applications.
- A clear vision and set of values was in place, which staff strove to demonstrate in their day to day work.

Summary of this inspection

However;

- Qualified nurses told us they felt under pressure and over worked. The provider had not adequately assessed current staffing levels and adjusted these based on risks and needs of the patients receiving care at the hospital.
- The provider had started to cluster bedrooms according to gender as patients were referred, and had consulted with carers about the need to meet the requirements of the Department of Health same sex accommodation guidance. However, there were no timescales in place to create single sex bedroom areas or provide a female only lounge.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Not all clinical staff had a clear knowledge of the MHA. There were no regular audits to ensure that the MHA was being applied correctly, but a MHA administrator worked on-site two days per week and was able to advise staff.

There were two patients detained under the Mental Health Act. We looked at detention records and saw that they had been appropriately completed and that the legal status of patients was clearly indicated.

Patients had access to an independent mental health advocate (IMHA). There was information on the ward indicating how patients were able to contact the IMHA, who visited the wards weekly. One of the detained patients had recently been referred to the IMHA to help them understand their rights. Patients' understanding of their rights was clearly documented.

Although a sign was displayed highlighting informal patients' right to leave the premises, this was not expressly communicated to patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

Fifty two per cent of staff had received training in the Mental Capacity Act (MCA) at the time of our inspection. Staff were generally clear about the MCA and knew when capacity assessments should be completed.

Capacity assessments for specific decisions and specific best interest decisions were documented in patient records. Third parties (either the patient, their relative or an advocate) were recorded as having been involved in most best interest decisions.

Staff obtained consent from patients before providing them with care. They understood their legal obligations on how to support people who could not consent to their own care and treatment. Staff accessed the MHA administrator for help and advice about the MCA.

There were significant delays to DoLS authorisations by the local authority. At the time of the inspection thirty two patients' DoLS assessments were awaiting authorisation. The MHA administrator had a clear system in place for tracking pending applications and for indicating when DoLS applications that were in place were due for renewal.

Requires improvement

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

- Ward layouts did not enable staff to observe all parts of the ward from the nurses' offices. However, this was mitigated through regular observations. If individual risks changed, patients were placed on one to one observations.
- Staff had completed a detailed ligature audit and knew where potential ligature points were. The risks associated with potential ligature anchor points were managed and mitigated through the use of one to one observations when required. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- The provider did not meet the requirements of the Department of Health same sex accommodation guidance. There was no clear timescale in place for the creation of single sex bedroom corridors or to provide a female only lounge.
- All three clinic rooms were fully equipped and had accessible resuscitation equipment. Equipment bags for immediate life support (containing oxygen cylinders, ligature cutters, defibrillators) were stored in three locations for access by nursing staff. Staff checked them every day but one of the defibrillators was overdue a portable appliance test, which we raised with staff during our inspection.
- Appropriate emergency medicines were available and at the time of our inspection the medicines storage process was under review to ensure that these were easily accessible by staff on all floors. Emergency medicines were supplied in tamper evident packaging with the expiry date clearly visible, and were checked regularly.
- The facilities were well maintained and visibly clean. Appropriate furniture was present including reclining armchairs to aid good posture.
- Handwashing facilities were available, and we saw that staff observed infection control principles including handwashing.
- Appropriate equipment was available in clinic rooms on each floor and on the second and third floors records showed that these had been calibrated. However, on the ground floor, scales used to weigh patients and a blood glucose monitor did not have records to show when these had been calibrated.
- Environmental risk assessments were completed monthly. Routine observations took place, where staff checked the environment and reported any faults. Maintenance issues were escalated and resolved promptly by on-site maintenance staff.
- Call alarms were situated throughout each ward for patients and staff to use to call for assistance.

Safe staffing

- Overall, the provider maintained safe staffing levels, however, qualified nurses were under pressure as a result of their workloads. A qualified nurse was rostered to work on each of the wards, supported by four care workers during the day, and two care workers at night.

Qualified nurses told us that they felt stressed and regularly missed their breaks. They were often away from the ward areas attending handovers or other meetings, meaning that there was not a qualified nurse present in ward areas at all times. Many of the care staff were new in post and some had no experience of working in care before so required a lot of support from qualified nurses to be able to carry out their duties.

- At the time of our inspection, the staff vacancy rate was 28%. The vacancies were for five qualified nurses out of an establishment of 14 and for four care workers out of an establishment of 43. The vacancy rate had decreased over the previous ten months following recruitment drives.The provider updated us after our inspection visit to advise that a further four qualified nurses had been recruited, leaving one vacant post, and 10 care workers, leaving four vacant posts.
- Vacant shifts were filled using regular agency staff. Most had worked at the service for a long time so were familiar with its operations and the individual patients. Some of the senior nurses occasionally worked bank shifts on the wards if there was a shortage of qualified nurses. Agency staff were given a structured introduction to the service on their first shift.
- Activity co-ordinators worked on each of the three floors and regularly helped care staff at meal times and with general observations alongside their activity co-ordinating work.
- The hospital manager had the authority to roster additional staff to cover enhanced one to one observations if needed.
- We did not identify any occasions where escorted leave and ward activities were cancelled or rearranged because of staffing issues.
- Staff turnover within the last 12 months was high. Twenty one percent of substantive staff had left. Staff and managers attributed the recent high staff turnover in part, to the process of transition to the new provider.
- Appropriate levels of medical cover were provided. Two consultant psychiatrists worked at the hospital, both for one day each week. A general practitioner was on site two days per week for all patients to access and provided a 24 hour on-call service for emergencies.
- A comprehensive range of training was mandatory for staff. In total 39 courses were identified as mandatory, some of which related to the specific needs of the patient group for example dementia awareness, end of life care, nutrition and falls prevention. However, at the time of our inspection training compliance in most areas was less than 75%. Key areas of low compliance included safeguarding adults at 50%, Mental Capacity Act and Deprivation of Liberty Safeguards training at 52% and food safety at 57%. The manager identified that whilst newly appointed staff completed some mandatory training during induction, not all mandatory training could be delivered in this period. An influx of new as a result of recent recruitment drives had negatively impacted upon compliance rates with mandatory training. A plan identifying key training priorities was reviewed by senior staff each month.

Assessing and managing risk to patients and staff

- Staff used standardised risk assessment tools to identify and manage individual patient risks. The majority of patients had detailed risk assessments completed on admission that were regularly reviewed. These included pressure care, use of bed rails, moving and transferring, and falls. During observation of and discussion with staff, we found that permanent members of staff demonstrated a sound understanding of individual patient risks and how to manage these. However, of the 23 patient records we reviewed, six patients' risk assessments lacked detail or had not been updated, despite being reviewed, to reflect the patients current risks and the plans to mitigate and manage these. For example, on the first floor one patient's risk assessment had not been updated following an incident where they assaulted a staff member. On the second floor, one patient's risk management plan in relation to evacuation in the event of a fire had not been updated to reflect that they were currently bedbound. This meant that for that new or agency staff amy not have a clear understanding of how to manage individual risks.
- Training for staff in how to support patients with moving and transferring safely and appropriately was mandatory. At the time of our inspection, 74% of staff had completed this training, which included an assessment of staff competence. Sufficient numbers of hoists and other moving and transferring aids were available to ensure that patients could be safely moved and transferred. However, during the course of the

inspection, we observed some examples of poor practice when staff supported patients with moving and transferring, some of which related to the use of hoists recently purchased by the hospital. We raised this during our inspection with the registered manager responded by bringing in a moving and transferring trainer to provide additional support and training to staff over a period of several days.

- We did not identify any unjustified blanket restrictions on patients.
- Access to each floor was via a locked door. Signs were displayed explaining informal patients' right to leave and this was also included in welcome pack documentation. Informal patients who were routinely prevented from leaving the building, did have Deprivation of Liberty Safeguard assessments pending, as they hadbeen assessed as being at risk if they were to leave the premises.
- There had been no incidents of seclusion, prone restraint or intramuscular rapid tranquilisation in the ten months to June 2017. A small number of patients were identified as having behavious that challenge, which could mean that staff held their limbs whilst providing personal care, to prevent the patient from striking out. The provider recognised that this constituted restraint and had developed guidance for staff on how this should be managed and monitored. This included identifying the behaviour in the patients care plan along with strategies to mitigate and manage it, and completion of an incident report on each occasion this type of restraint was used. However, we saw that for one patient on the first floor, who was identified by staff as having behaviours that challenge that could result in their being restrained during personal care, this was not appropriately reflected in their care plan and an incident report had not been completed on each occasion they had been restrained in this manner.
- Staff undertook one to one observations when patients presented with increased risks, including the risk of self-harm. One patient was on one to one observation during our inspection. A set number of patients could be placed on one to one observations under the regular staffing establishment. Above this threshold, additional staff were brought in to support any additional observations. Staff regularly reviewed patients who were subject to one to one observation to restrict them as little as possible.
- Not all staff had a clear understanding of safeguarding or their responsibilities. Whilst safeguarding adults training was mandatory, at the time of our inspection, the compliance rate was 50% and three months after our inspection visit, this had started to increase to 65%. Of the 26 staff we spoke with, five were not clear what constituted a safeguarding concern. Two incident records we reviewed included potential safeguarding concerns, but had not been flagged as such. Most potential safeguarding concerns had been appropriately identified and the service had a system in place to monitor current safeguarding concerns and required actions. However, for one patient we saw that an entry in their care and treatment record indicated a potential safeguarding concern that had not been identified and appropriate action taken.
- Staff managed medicines well. Prescription charts were correctly filled in and included information about patient demographics and allergies. Documentation detailing the legal authority to administer medicines to individual patients was readily available. The pharmacist had screened all the prescription charts and had made appropriate clinical interventions to improve medicines optimisation. We saw that medicines for use 'when required', including sedative medicines, sometimes required for patients who were agitated, were regularly reviewed and were deleted from prescription charts when they were no longer required. However, there were two occasions where medicines were not correctly ordered by agency staff, resulting in missed doses. This had been appropriately escalated and managed to minimise the risk to patients involved. Controlled drugs were correctly stored and recorded correctly.
- Medicine fridge and clinic room temperatures were recorded each day. We identified some occasions when clinic room temperatures were out of range, but appropriate action had been taken to address this to minimise any impact on people using the service. Air conditioning had recently been installed in all the clinic rooms to prevent high room temperatures that could have led to damage to medications.

- Medicines were stored securely in locked cupboards and medicines trolleys.
- Systems for disposal of pharmaceutical waste were in place. However, we identified a collection of out of date vacutainers, used to collect blood samples, and an out of date suture kit, used to close surgical incisions or wounds, in the ground floor clinic room. These were subsequently removed during our inspection.
- Staff took appropriate measures to minimise the risks associated with pressure areas. Waterlow assessments, used to assess the risk of development of pressure sores, were completed and regularly updated. Patients who were bed bound were regularly turned to prevent the development of pressure sores.
- Falls assessments had been completed for patients and appropriate equipment such as crash mats and low profile beds were used when patients were at risk of falls. However, staff did not identify that wearing inappropriate footwear could put patients at risk of falling. We observed that three physically mobile patients wore footwear that was either too big or was not safely secured to their feet, increasing the risk of slips, trips and falls. We escalated this issue to staff during the course of the inspection.
- There were several quiet spaces both on the wards and off the wards available for children to visit.

Track record on safety

- No serious untoward incidents requiring investigation had occurred since the provider had taken over the provision of the service.
- Eight incidents had taken place between August 2016 and May 2017. Four of these incidents related to medication administration. These incidents were correctly reported and investigated, and an action plan had been put into place to improve medication management. This included tailored medication management training, medicines competency checks for staff and training in managing the physical health conditions that featured in the incidents. Weekly medicines audits were also completed by the pharmacist. This was used by senior staff to identify training needs.
- The other incidents included two staff altercations, a pressure ulcer and an unexplained injury. The unexplained injury had been escalated to the local authority safeguarding team. The staff performance management protocol had been followed to prevent similar altercations involving staff from happening again.

Reporting incidents and learning from when things go wrong

- Although staff reported incidents regularly, we identified occasions when they did not report incidents they should have reported. For example, we identified two separate injuries to a patient that had taken place on the ground floor that had not been reported as incidents.
- All staff could report incidents by phoning a 24 hour telephone line. The telephone operator then filled in an electronic incident form on the staff member's behalf. Incident data was then sent to the deputy hospital manager, who had oversight of all incidents via a database.
- Staff who we spoke with had a good understanding of their Duty of Candour, and told us how they would explain to the individual and their relatives if something went wrong. Duty of Candour was included in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
- Learning following incidents was captured and changes were made to prevent similar incidents from recurring. Senior staff were able to tell us about learning points or ways in which the service had changed to prevent incidents from recurring. For example, a diagram of cup sizes was now displayed on the wards to prevent incorrect recording of fluid intake following an incident when a patient became dehydrated. The service had also worked to reduce the number of falls incidents by introducing grip socks for patients and increasing the lighting at night to prevent patients from falling on their way to the toilet. However, a robust system to routinely share learning from incidents with all staff was not in place, for example, learning from incidents was not routinely discussed at staff meetings.
- Staff were debriefed following incidents. This usually took place during staff meetings, but separate debrief sessions could be set up following serious incidents to support staff.

Requires improvement

Wards for older people with mental health problems

Are wards for older people with mental health problems effective?
(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Comprehensive and timely assessments that identified patients' needs were completed for those who had recently been admitted. However, staff could not access these for patients who were admitted under the previous provider and new assessments had not been completed
- Patients received annual physical health assessments. A general practitioner attended the hospital twice per week and a lead physical health nurse worked three days per week. We found ongoing monitoring of physical health conditions detailed in the 23 patient records we reviewed. National early warning signs (NEWS) were used to monitor physical health observations such as blood pressure, pulse and temperature.
- However, on the second floor we identified three patients whose NEWS scores were either wrongly completed or not completed when they should have been. One patient with diabetes required their blood glucose to be monitored daily. We found that their blood glucose had only been recorded twice during a six week period in spring 2017. This meant that the patient was at risk of a medical emergency if abnormal blood glucose levels went undetected by staff.
- Care plans were personalised but lacked detail. Each patient had a detailed 'about me' section in their records, which included details about their family, previous occupation and interests. Care plans included details about pressure care, physical health, moving and transferring, food and nutrition, falls and managing violence and aggression. However, one patient record indicated that they were diabetic, so required a diabetic diet. The care plan did not detail what this diet should consist of. Another patient had been receiving a pureed diet for more than a year, but this did not feature on their care plan. There were no details about communication in the care plan of a patient who required non-verbal communication.
- Patient files were large and often difficult to navigate and would have been difficult for new staff and agency staff to follow. Patient care records were paper based and easily accessible to staff.

Best practice in treatment and care

- Staff managed medicines in line with National Institute for Health and Care Excellence (NICE) guidance. Nurses completed a 'gap analysis' audit of prescription charts each day to ensure that all doses of medication that had been administered were signed for.
- We observed that physical health needs were discussed in detail during ward rounds. Notes from GP consultations were included in care records, along with follow up actions. Outpatient appointments and follow up appointments were included in patient records. Staff proactively referred patients to specialists when required, such as podiatrists.
- Patients' nutrition and hydration needs were assessed and met in most cases. Ongoing assessments including malnutrition risk assessments were regularly completed and included in patient files. We saw evidence that a patient had been referred to a dietician when needed, and two patients had detailed dietary plans in place on the ground floor as they were receiving pureed diets. However, Malnutrition Universal Screening Tool (MUST) scores were not always correctly calculated. We identified three separate patient records where scores were incorrectly calculated, causing a potential risk that patients would not receive the correct nutrition.
- The provider did not use any measures to assess outcomes for patients. The provider stated they would consider ways in which they could monitor outcomes from August 2017.
- The pharmacist completed a weekly audit of medicines.

Skilled staff to deliver care

- The hospital team consisted of nurses and doctors. The service had not been commissioned to provide physiotherapy, speech and language therapy, occupational therapy and dieticians. The local clinical commissioning group had instead established a

pathway for accessing these services from other providers. Staff told us they were not always able to access these services for patients when they made referrals. On some occasions, the provider had commissioned these services privately when following the local commissioning arrangements had failed. The provider had worked hard to resolve this issue with commissioners during the months leading up and following our inspection visit.

- Two of the care and treatment records that we looked at demonstrated that patients were not always able to access the necessary professional disciplines to support their care and treatment. For one patient at risk of falls a referral to a physiotherapist had not been made. For the second patient a referral to the physiotherapist had been made some months previously, but this had not been followed up.
- Most of the care workers had been employed in recent months and were not experienced. Their previous employment did not tend to be in the health and social care industry. Qualified nurses had a greater level of experience working in similar jobs.
- New staff received an induction in line with the Care Certificate Standards. This also included a thorough introduction to all the patients.
- Staff did not receive regular one to one supervision from their managers or identified clinician. We looked at six records in detail and a supervision compliance matrix. The compliance matrix showed that no staff were receiving regular monthly one to one supervision, in accordance with the provider's policy and procedure. Seventy six per cent of staff attended at least one supervision session between August 2016 and April 2017. When supervision had taken place, supervision records indicated that these did not routinely and consistently address clinical practice and focused on management issues. Following our inspection, the provider updated us, advising that all nurses had undertaken training in clinical supervision, and the provider was working to embed clinical discussions in staff supervision sessions.
- Not all staff had received an annual appraisal. Seven staff who had been in post for longer than 12 months had not received an appraisal in the last year. In total, only 48% of staff had received an annual appraisal at the end of April 2017.
- Qualified nurses received specialist training in epilepsy management to help them to care appropriately for patients with epilepsy.
- Staff performance issues were addressed promptly and effectively.

Multidisciplinary and inter-agency team work

- Regular ward rounds were attended by a consultant psychiatrist and a qualified nurse. Each patient was discussed at least every three weeks. Reviews were clearly recorded in patient care and treatment records. Discussions during the ward round were constructive and detailed. Staff reviewed 'do not attempt cardiopulmonary resuscitation' statuses routinely during each patient review. A medical and nursing summary was given, followed by a discussion about mental and cognitive state, vital signs, eating and drinking, risks including falls and pressure care. Discussions about the need to refer patients to specialists, including audiologists and dieticians took place.
- Nursing staff completed a detailed handover every morning. Updates were given about each patient and any incidents or changes to the way the service was run were communicated.
- Some patients had care coordinators who the service worked closely with to plan follow up care, although the majority of patients were receiving continuing care. The service was in close contact with the GP who visited twice per week, and was able to communicate directly with the local authority for advice from social services or about safeguarding. Despite commissioning challenges, the service had developed good relationships with the tissue viability nurse, who assisted staff in preventing, managing and treating pressure sores.

Adherence to the MHA and the MHA Code of Practice

- Eighty three per cent of staff had received introductory level training in the MHA, but some did not show a good understanding of the MHA, code of practice and the guiding principles. Following our inspection, the

provider added enhanced face to face MHA training to their list of mandatory training. A MHA administrator worked at the service two days per week, and staff approached them for advice about the MHA. MHA papers were examined by them on admission.

- Two patients were detained under the MHA. All MHA paperwork was completed correctly and stored appropriately. Both patients were granted leave under section 17 and had access to their leave forms. Leave was regularly reviewed during ward rounds. Consent to treatment forms were completed and attached to medication charts where applicable, and patients' rights were regularly explained and their understanding of their rights was clearly documented.
- The MHA administrator had good oversight of MHA paperwork and expiry dates, and staff knew how to approach them for advice about the MHA. There were no regular audits to ensure that the MHA was being applied correctly.
- An independent mental health advocate (IMHA) visited the service weekly and could be contacted at other times by phone. They had been contacted to support one of the two detained patients understand their rights.

Good practice in applying the MCA

- Fifty two per cent of staff had received training in the Mental Capacity Act (MCA) at the time of our inspection. Staff were generally clear about the MCA and knew when capacity assessments should be completed.
- A policy on the MCA and DoLS was available for staff to refer to and the MHA administrator also offered advice to staff about the MCA.
- Capacity assessments for specific decisions and specific best interest decisions were documented in patient records. Capacity assessments for consent to treatment were completed to a good standard. Third parties (either the patient, their relative or an advocate) were recorded as having been involved in best interest decisions. However, a do not attempt cardiopulmonary resuscitation (DNACPR) notice was put in place for a patient on the ground floor without their involvement or involvement of a family member, close friend or an advocate.
- Some patients needed their medicines administered covertly. Where this was identified, staff completed an appropriate assessment involving detailed discussions with doctors, nurses and pharmacists. Staff told us that an independent advocate was usually involved when covert medication was considered, but their involvement was not clearly documented in the records we reviewed.
- The MHA administrator had good oversight of the MCA and DoLS and could easily refer to a spreadsheet which told them when patient's DoLS authorisations were due to be renewed to prevent lapses.
- Six patients had DoLS in place and 32 patient's DoLS assessments were pending approval from the local authority. DoLS applications that had been made met the threshold of requiring continuous supervision and control and not being free to leave.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

- The quality of staff interactions with patients varied. On the first floor our observations of interactions between staff and patients were responsive, discreet and respectful. However, our short observational framework for investigation (SOFI) on the second floor showed that interactions between staff and patients were task orientated. A SOFI is an enhanced observation of interactions that patients have with others during a timeframe of around one hour. Staff asked patients direct questions such as whether they wanted a cup of tea, rather than engaging in meaningful conversation with them.
- Staff demonstrated an in depth understanding of individual patient's needs and interests. For example, activity coordinators had developed detailed background information for each patient, covering their likes and dislikes, family details and life history.
- We spoke with two patients and five relatives who were present during our inspection.All five relatives who we

spoke with said that staff were friendly and treated them and their relative with dignity and respect. They told us that staff were open with them and telephoned them if there had been a change to their relative's care.

The involvement of people in the care they receive

- Each patient was provided with welcome information on admission to the service to help orientate them.
- We found that patients and their carers had been involved in care planning where they were able to contribute. Each patient had a life history section in their care records. These were generally detailed and included photographs, family details, previous work and personal interests. All but one of the carers who we spoke with felt involved in their relative's care. Three of them told us that they had contributed to and received copies of care plans. Two told us that they regularly met with staff to discuss their relative's care, and carers were routinely invited to attend review meetings.
- An advocate visited the hospital every week. Staff regularly referred patients to the advocate and some patients were able to refer themselves. When new patients were admitted, the advocate made themselves known to them. Posters about the advocate were displayed and carers could refer their loved ones to advocacy. The advocate regularly attended care programme approach meetings and was recorded as having been present to represent patients when best interest decisions had been made.
- Families and carers were involved in decisions about the service and provided feedback. Regular carers meetings had been introduced at the end of 2016. All of the carers who we spoke with spoke very positively about the meeting. Carers gave feedback about the service and received support and advice from other carers. For example, carers had asked for a new DVD player, and for somebody to be permanently stationed at reception because they were having to wait too long to access the building during meal times. There were posters displayed about the carers' group and all carers were encouraged to attend.
- Daily community meetings took place on each floor but patients were not encouraged to provide feedback at meetings. Staff did not proactively encourage patients to attend. The service was not using patient satisfaction surveys. However, leaflets about how to provide feedback about the service were displayed, and a comments box was positioned at reception.
- We did not identify any examples of patient involvement in decisions about the service. However, most patients were living with advanced dementia, and staff did consult with the carers' group about decisions about the way the service was run.
- Many patients had advance decisions in place. Do not attempt cardiopulmonary resuscitation (DNACPR) notices were correctly displayed in patient records and most showed that a third party had been involved in making the decision (either the patient, a lasting power of attorney or an advocate). However, we found one DNACPR on the ground floor that was competed under the previous provider two years before that contained a lack of current information, which was not in line with best practice. Staff were made aware of this during our inspection and were considering arranging a new advance decision. One patient's records on the second floor contained a blank DNACPR form, which could have been confusing to staff in an emergency. One patient on the ground floor had a DNACPR in place, but a third party was not recorded as having been present when the decision was made. Third party involvement is a legal requirement to ensure that an amicable, balanced decision is made in the best interests of the patient.

Are wards for older people with mental health problems responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

- The service provided continuing care to people with mental health conditions. Beds were normally given to patients for life. Therefore, if patients went on leave or were admitted to a general hospital, they were able to return to their own bedroom. Bed occupancy across the hospital was usually between 98 -100%. Average length of stay for patients who were discharged between August 2016 and April 2017 was 117 days.

- Some patients had been discharged to alternative placements such as nursing or care homes after the provider acquired the service. The provider was negotiating with the clinical commissioning group over a set of admission criteria, to ensure that future patients' needs would be best met in a hospital environment. In future the provider planned to take a different range of patients who would not be allocated a bed for life but would have their immediate care needs met and then be discharged or moved to alternative suitable placements such as a care home.
- Patients did not usually need to move bedrooms for reasons other than clinical reasons. Beds were available for patients who lived in the local area. Although most patients were receiving continuing care, when patients had been discharged, this was planned in advance and took place during the day.
- There were no examples of delayed discharges at the time of the inspection.

The facilities promote recovery, comfort and dignity and confidentiality

- Staff acknowledged that work was required to improve the environment to ensure it was dementia friendly, which would help to promote the dignity of patients who often felt disorientated. Wards were plainly decorated and there was a lack of dementia friendly signage and sensory stimulation in communal and outdoor areas, which would benefit the patient group. There were no information boards to help orientate patients to the date, season and upcoming events. The provider had a plan in place to gradually and sensitively introduce changes to improve the environment, and had recently introduced new furniture
- The building was bright and contained a full range of rooms and equipment to support treatment and care. Clinic rooms were situated on each floor, and provided enough space for physical examinations and consultations to take place. Quiet areas were available in addition to patient lounges. A large multi-purpose room was situated away from the main ward areas, and this was used for group activities and carers meetings. A hairdressing salon was situated on site, as well as a room where relatives and carers could stay overnight.
- Patients could use their own mobile phones at any time or use telephones to make phone calls in private rooms.
- Outside space was limited. The first and second floors had access to small balconies, whilst the ground floor had access to a patio at the front of the building. External doors were kept locked, and patients either asked or waited to be invited by staff to go outside.
- Food options were well balanced. Meals were prepared on site and catering staff took into account patient's dietary needs. We observed some patients receiving pureed food which consisted of nutritious, balanced food items. Cold drinks were available in ward areas for patients to help themselves to. Hot drinks and snacks could be accessed by staff for patients, most of whom were unable to prepare these for themselves due to mobility issues.
- Staff had a good understanding of the needs of patients who required assistance during meal times. Staff patiently assisted patients who required help with feeding and relatives were also able to help feed patients. Staff also had a good knowledge about the types of foods that individual patients either liked or could not have due to special diets.
- Meal times were chaotic and task oriented, particularly on the ground and second floors. Food took one hour and a half to be served to some patients on the ground floor and some food was served that was no longer hot. Two relatives told us that they did not feel there was enough staff at meal times.
- Patients were dressed in a manner that preserved their dignity, although some had unsuitable foot wear. Patients also had access to lockable cabinets in their bedrooms to keep their possessions safe. Staff were also able to lock bedroom doors at the request of patients.
- Staff did not complete individualised activity plans to help promote the recovery and wellbeing of individuals. One to one activities and community outings were not regular enough. The service acknowledged that this was a key focus area for them. A patient on the second floor told us they were often bored and no longer got the opportunity to go on outings.
- Regular group activities took place and patients were encouraged to take part. Details about group activities that patients had attended were in their care records but their identified individual interests did not tie in to a

Requires improvement

Wards for older people with mental health problems

personalised activity plan. Group activities that took place included parachute games, cinema sessions, reminiscent music sessions, pampering and hand massage.

Meeting the needs of all people who use the service

- The premises were easily accessible. Several patients used wheel chairs. There was level access throughout the building with lifts to all floors, a ramp to the main entrance and accessible en-suite facilities.
- Leaflets about how to complain, patients' rights and types of treatment were available to patients, though there was a lack of information about local services. Some information, such as the complaints leaflet, was available in an easy read version for people with cognitive difficulties. Leaflets were not routinely available in different languages. Staff told us they would contact an interpreter if leaflets needed to be read to patients in different languages.
- Patients were well supported with their religious and spiritual needs. During our inspection, one patient and one staff member were being supported to observe Ramadan. A multi-faith religious leader visited the hospital to meet with patients, and they were able to request the attendance of specific ministers of religion. Another patient visited a local synagogue with friends and had been accompanied by staff on several occasions. Two patients on the ground floor received a halal diet, which was detailed in their care plans and a previous patient had been supported to receive kosher food.
- Patients and staff came from different backgrounds and cultures. Staff had access to a telephone interpreter service, though this was rarely used because staff and patient family members were used to interpret in most cases. We identified a patient with Romanian as their first language. Staff had compiled a list of basic words and instructions in Romanian that they could communicate with.
- The provider was planning to mark cultural events such as black and lesbian, gay, bisexual and transgender (LGBT) history months in the future. Staff had already been in consultation with the carers' group about how they could raise awareness and understanding to better meet the needs of LGBT patients and protect their rights.

Listening to and learning from concerns and complaints

- Two complaints about the Butterworth Centre were received by the provider in the last 12 months, and both were upheld. Both complainants were relatives of patients. One was made about a missing possession; the other regarded a lack of family contact when the complainant's relative was admitted to a general hospital. Investigations into these complaints had been completed.
- A clear complaints policy was in place and was easily accessible to staff. Staff were clear about the ways in which people could complain and give feedback, and information about how to complain was displayed for people to see, including an easy read complaints leaflet.
- Learning from complaints and incidents took place. The service was in the process of embedding learning from complaints and incidents at staff meetings.
- Routine feedback and informal complaints and compliments were gathered at the carers' meeting. Staff told us about changes that had been made as a result of carers' feedback, such as the purchase of a new DVD player and ensuring a staff member was stationed at reception to unlock the front door during meal times to prevent people from waiting a long time to get into the building.
- A comments box was situated in the reception area, but comments had not yet been collated and analysed by staff to draw themes.

Are wards for older people with mental health problems well-led?

Good

Vision and values

- The provider had developed a mission statement, which was 'keeping kindness at the heart of our care.' The provider had recently created a new set of values: integrity, ambition and quality of care. These were detailed on posters, discussed at staff meetings and

discussions about embedding the values were taking place at regional managers meetings. Staff who we met demonstrated that their personal values aligned with those of the organisation.

- Most staff were familiar with the senior managers in the organisation. Directors occasionally visited the hospital from the head office and spoke to patients and staff during their visits. The regional manager was frequently present and made themselves known to all staff.

Good governance

- Governance systems were in place, but were not always effective in ensuing quality delivery of the service's responsibilities. Mandatory training compliance was monitored, but staff competencies were not assessed thoroughly. Staff supervision was sporadic and not all staff had received an annual appraisal. The provider had not effectively re-assessed staffing levels to ensure there were sufficient staff to safely deliver care and meet the needs of patients. Not all staff correctly identified and reported incidents, including episodes of restraint and safeguarding incidents.
- A quality improvement meeting had recently been introduced, which we observed. Qualified nurses attended this meeting and the agenda included feedback about the service, a review of incidents and complaints and staff training needs. Staff discussed the agenda items with a particular focus on the new care workers who had not worked in a similar environment before. Other constructive conversations about learning from incidents and complaints were not yet embedded in this meeting.
- Key performance indicators (KPIs) were collected to gauge performance of the team. These fed up to the corporate governance meeting, which was attended by directors in the organisation.Indicators included admission delays, care plan and GP review dates, and personalised activities.
- Commissioners had visited the hospital in January 2017 to undertake a full audit which included care planning, staffing levels, training and supervision for staff.Clinic rooms had been tidied in response to the commissioner's audit and more suitable storage areas for some equipment had been sought. The provider had also started working with commissioners to establish a more person centred programme of activities. The pharmacist completed a weekly audit, which covered medicines and the clinic rooms. Staff received audit results via the pharmacy contractor's electronic system. The hospital manager had sufficient authority to make changes and alter staffing levels when needed. However, the staffing establishment had not been adequately reviewed to ensure it met the needs of the patient group. They were supported by a team of administrators, including a part-time MHA administrator.
- Staff completed a risk register, which fed into the provider's risk register. A risk register is a repository for all risks associated with the service and includes information about how they can be mitigated. The hospital manager was aware of the key risk areas in the hospital, including the need for easier access to a full range of professional disciplines and inconsistencies in incident reporting thresholds.
- Staff were aware of the need to ensure the environment was more dementia-friendly. This featured on the providers risk register and a plan was in place to make gradual, sensitive changes to the environment to minimise disorientation to patients.
- Staff identified patients who would benefit most from input from other professional disciplines and considered commissioning services from other professional disciplines privately for those most in need. Interventions were in place to prevent falls, such as use of grip socks and a longer term plan to replace flooring.

Leadership, morale and staff engagement

- Feedback from staff was regularly collected at meetings and staff engagement sessions. Engagement sessions provided a productive, action focussed forum for capturing feedback, and the provider produced an action plan following staff engagement sessions.
- Staff sickness was 4.5%, and no individual concerns were raised regarding bullying or harassment. Staff were positive about the new provider and management team. They felt that recent changes such as the introduction of the carers meeting and increased focus on good medicines management had improved the service.
- Staff were supported by their colleagues and managers. They felt that they could raise concerns without fear of victimisation and we did not come across any incidents

of bullying or harassment amongst the staff. Staff told us they could feed back during one to one supervision and during team meetings. A whistleblowing process was in place, and the whistleblowing procedure was displayed for staff. Senior managers in the organisation visited the hospital and staff told us they were approachable and felt comfortable raising concerns with them. Information was also transferred between management tiers through a corporate governance meeting.

- All the qualified nurses we spoke with said they were under pressure and did not find their workload manageable. However, morale was generally good and new staff felt well supported by their colleagues.
- Staff were able to accessleadership and management courses, including diplomas in leadership and management, leadership in dementia, an introduction to care management development programme and a senior management development programme for middle managers.
- Staff were familiar with the Duty of Candour and knew when to be open and transparent with patients if things went wrong. This was covered as part of the provider's MCA and DoLS training.
- Staff were offered the opportunity to give feedback on services and input into service development during the six-weekly full team meeting.

Commitment to quality improvement and innovation

The service was not involved in any research or national quality assurance programmes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure it meets the requirements of the same sex accommodation guidance to protect the privacy and dignity of patients
- The provider must ensure that all staff are able to access regular supervision sessions and receive an annual appraisal
- The provider must ensure that all staff complete mandatory training
- The provider must ensure that all staffunderstand what constitutes a safeguarding concern and have systems in place to ensure all incidents of safeguarding are correctly reported and acted upon
- The provider must ensure that patients are handled and moved safely and that it has a robust system for assessing the competency of staff members to move and handle patients safely
- The provider must ensure that detailed, up to date risk assessments are in place for all patients
- The provider must ensure care plans contain sufficient detail about the needs of patients to enable agency or new staff to deliver appropriate care and treatment

Action the provider SHOULD take to improve

- The provider should ensure individualised activity plans, including one to one sessions and outings where appropriate, are in place for all patients to promote their recovery and wellbeing
- The provider should continue its work to provide a dementia friendly environment to meet the needs of patients living with dementia
- The provider should ensure national early warning sign (NEWS) scores are correctly completed by staff
- The provider should ensure malnutrition universal scoring tool (MUST) scores are correctly calculated by staff
- The provider should continue to work with commissioners to improve timely access to therapies and other professional disciplines
- The provider should ensure staff have a good understanding of the Mental Health Act (MHA), the code of practice and the guiding principles
- The provider should identify ways to encourage patients to provide feedback about the service
- The provider should ensure food is served in a timely, pleasant and sociable manner during meal times
- The provider should ensure staff clearly document independent advocates' involvement in best interest decisions, such as administration of covertmedications
- The provider should ensure staff support patients to wear appropriate footwear to help prevent falls, slips and trips
- The provider should ensure emergency medications are stored in a well organised manner so staff can locate them easily in an emergency
- The provider should ensure medical equipment used to monitor patients' physical health observations is correctly calibrated
- The provider should ensure that all incidents of restraint are correctly identified, recorded and reported by staff
- The provider should ensure that learning from incidents is discussed with all staff and embedded in practice
- The provider should review the numbers of qualified nurses rostered on each shift and ensure they are deployed in a way that meets the needs of patients

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured the privacy of patients by ensuring they provided care and treatment in an environment that met the requirements of the same sex accommodation guidance. This was a breach of regulation 10 (1) (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured staff received regular one to one supervision to enable them to carry out their duties. Not all staff had completed mandatory training required to enable them to safely care for patients. This included moving and transferring training. This was a breach of regulation 18 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that patients were protected from abuse.

This section is primarily information for the provider

Requirement notices

The provider had not ensured that all staff had completed mandatory safeguarding training and were confident and competent in identifying safeguarding concerns and taking appropriate action.

This was a breach of regulation 13 (1) (2) (3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure detailed, up to date risk assessments and management plans were in place for all patients. Care and treatment records did not always contain sufficient detail of patients' individual needs to enable new or agency staff members to meet the patients' needs safely. This was a breach of regulation 12 (1) (2) (a) (b) (e) (I)