The Breightmet Centre for Autism

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

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.

Overall summary

This was a focussed inspection on elements of the safe key question only. Therefore, we did not rate the service in relation to this inspection.

We found the following:

- Care plans and risk assessments did not always reflect patients current care and treatment needs. Staff were not always providing care and specific interventions in line with patients care plans.
- Staff did not effectively assess and manage risks to patients.
- Staff were not always managing and administering medicines safely.
- There were not enough staff to ensure that patients could be cared for safely.
- Managers had not always ensured that staff were clear who would carry out essential duties such as checking environmental risks and identifying designated responders.
- Governance systems were not effective and were not picking up when policies needed updating or when staff were not adhering to them.

Summary of findings

As a result of the concerns we found during this inspection, we took urgent enforcement action to impose conditions on the provider's registration requiring the hospital to temporarily restrict admissions and provide assurances in relation to the safe care of patients. As a result of positive steps taken by the provider to improve the safety of patients the conditions have been removed.

Summary of findings

Contents

Summary of this inspection

Background to The Breightmet Centre for Autism

The Breightmet Centre for Autism is an independent hospital which is provided by ASC Healthcare Limited. It is situated in the Breightmet district of Bolton, Greater Manchester. At the time of the inspection the provider was registered to deliver the following regulated activities from this location:

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

The centre provides enhanced services and support to adult patients with a learning disability or autism, who are either detained under the Mental Health Act or admitted informally. The hospital takes admissions from across the country.

The hospital had not had a Registered Manager since April 2020. The hospital manager was in the process of applying to be the registered manager.

The hospital accommodation is divided into four separate apartments, located over two floors, each interconnecting with another. Each multi occupancy apartment consists of four or five-bedroom suites with full ensuite facilities and shared communal spaces. There is a separate linked annex which contains staff offices and some further shared communal resources such as an activity room and a family room.

At the time of our inspection, there were six patients residing at the hospital, across three apartments. All of the patients were detained under the Mental Health Act.

The hospital was registered with the Care Quality Commission in 2013. There have been seven previous inspections including one which took place in June 2019. During the inspection in June 2019 a number of serious concerns were raised, and we used our powers under section 31 of the Health and Social Care Act to take urgent immediate enforcement action against the provider. The following conditions were imposed on the providers registration by the First-Tier Tribunal

1. To restrict admissions until 30 April 2020 to one new patient every three weeks, subject to a maximum of 12 patients.
2. To report monthly to CQC on risk assessments and care plans for all new patients until CQC consider this no longer necessary.
3. To report monthly to CQC on governance systems and processes to ensure safe, effective and responsive care and treatment for patients until CQC consider this no longer necessary.
4. To report to CQC the views on service quality of families, staff and stakeholders using an appropriate quality audit toolkit by 30 April 2020

As a result of these concerns, NHS England asked Mersey Care NHS Foundation Trust to take over the running of the hospital.

In November 2019 a tribunal decided that ASC Healthcare Limited should take back control of the hospital. In November 2019 the hospital was placed into special measures and NHS England tasked Bolton Clinical Commissioning Group to convene a quality surveillance board to oversee the necessary improvements until NHS England /Improvement, ACS (Healthcare) agreed or when changes to existing governance arrangements made it necessary. In December 2019 the report from the June inspection was published, this report rated the hospital as inadequate in all five domains (safe, effective, caring, responsive and well led) and inadequate overall.

The hospital was also inspected in February 2020, this inspection found that the service had improved in a number of areas but that there were still some areas of concern. The hospital was given an overall rating of requires improvement, good for caring and responsive, requires improvement for effective and well lead and inadequate for safe. Due to the hospital remaining inadequate for safe it was kept in special measures.

Summary of this inspection

Our inspection team

The team that inspected the service comprised two CQC inspectors and one inspection manager. Due to the short notice of the inspection, it was not possible to take an expert by experience.

Why we carried out this inspection

We carried out this inspection as a result of a number of concerns that were raised at a local authority safeguarding strategy meeting that we attended.

We also received a number of anonymous reports from members of the public that there were issues with safe care and treatment of patients at the hospital. As these concerns correlated with information we had received from other stakeholders at the time, we made a judgement that it was necessary to carry out an unannounced focussed inspection to assess patient safety.

How we carried out this inspection

As this inspection was carried out at short notice and was in relation to concerns about patient safety, we focussed on key lines of enquiry in the safe domain.

During the inspection visit, the inspection team:

- visited all apartments at the hospital, looked at the quality of the environment and observed how staff were caring for patients
- spoke to nine members of staff including support workers, a nurse, a manager and a lawyer
- looked at two care and treatment records of patients
- carried out a specific checks of the medication management processes 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 did not speak to patients or carers as part of this inspection.

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?

We did not rate safe at this inspection. We found examples of unsafe practice.

- Staff did not effectively assess and manage risks to patients. This meant that staff were not applying a coordinated approach to the delivery of safe and effective care for all patients. The communication needs of two patients were not being managed effectively, therefore staff were not clear how to meet the needs of these patients.
- Staff were not always following patients care plans and providing specific interventions contained within care plans which would have enabled them to better protect the privacy and dignity of patients. It was not always clear that guidance in care plans which stated a patient should have a consistent staffing team was being followed.
- Language in one care plan, which was a historic care plan in the records was derogatory and negative and could lead to staff taking a negative approach to the way they cared for the patient.
- The service did not have processes to safely prescribe, administer, record and store medicines. The policy was in draft form, it did not provide guidance for staff in managing medicines safely. It did not reflect or reference legislation or best practice guidance, including consideration of the Mental Health Act, Mental Capacity Act and controlled drugs legislation. In addition, there were a number of errors in the management and recording of prescriptions.
- There were insufficient numbers of staff recorded as on duty to enable them to carry out prescribed patient observations safely. It was not clear how staff would take breaks and there was evidence that staff spent long periods continuously supporting the same patients.
- Managers had not always ensured that staff were clear who would carry out essential duties such as checking environmental risks and identifying designated responders.
- Systems and policies were not effective to be able to support staff to deliver safe and effective care and treatment. Systems and policies were not being effectively monitored to enable managers to make changes where they might have been necessary.

However:

Summary of this inspection

- The physical environments were safe and clean and the provider complied with same sex accommodation guidance.

Wards for people with learning disabilities or autism

Safe

Are wards for people with learning disabilities or autism safe?

Safe and clean care environments

All ward areas were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The hospital had recently undergone an extensive refurbishment which included all the patient apartments.

Safety of the ward layout

The hospital complied with the Department of Health same sex accommodation guidance as there was no mixed sex accommodation.

Staff could observe patients in all parts of the wards. Closed circuit television (CCTV) was in place in communal areas which allowed staff to review incidents where necessary.

However; we found that staff duties detailed on the allocations sheet that related to safety were often not delegated to any individual for example; who was carrying out the security checks, who was allocated to medication or who was carrying out environment checks. For example; in May 2020 on apartment three, ligature and security checks were only allocated 15 times out of a possible 62 shifts over days and nights. Managers told us that these duties were documented elsewhere and that there were different mechanisms for carrying them out. This could cause confusion for staff and result in these duties not being carried out.

Following our inspection, the provider supplied further evidence which showed that security checks were not always allocated. In the information supplied security checks were allocated on a total of 47 out of 62 (75%) occasions on apartment three, leaving a total of 15 occasions when security was not allocated.

Safe staffing

We reviewed attendance registers for all day and night shifts during May 2020. These were daily registers completed by staff at handover each morning and night. We cross referenced these with shift allocation sheets for each apartment, with totals of 24 allocation sheets for apartment two, 51 allocation sheets for apartment three and 56 allocation sheets for apartment four. Shift allocation sheets were used to allocate staff to observations, breaks and tasks for the shift, including response staff, fire wardens, activities, meals and cleaning duties.

Staff worked a 12-hour shift pattern, one shift for days and one shift for nights. The number needed per day shift as indicated on the duty sheets for May 2020 was 18 staff per shift for the whole hospital up to 27 May 2020 when this number increased to 19 staff per shift. It was not clear how this number had been calculated. At the time of this inspection, all six patients were nursed on enhanced observations. The total number of observing staff required per day was 20 staff, to facilitate two 5:1 observations, three 3:1 observations and one patient nursed on 1:1 observations.

There were nine day shifts during May 2020 where there were 19 staff or more on duty. This meant that on the remaining days, there were not sufficient staff on duty to safely cover patients prescribed observation levels. This meant that patient observation levels changed daily depending on the number of staff available to facilitate them.

For example; one patient's prescribed observation level was 5:1. This meant five staff were needed to observe that patient. (All five staff may not always be needed to be in close contact with the patient, however, they needed to be readily available). They were observed by four staff during the day on five occasions during May 2020, three staff on five occasions and four staff for three hours on one other occasion during May 2020 and the remainder of the day with three staff. On one day during May 2020, only one staff member was allocated from 5-8pm. On none of the allocation sheets for this apartment were there five staff allocated to this patient's observations during the day. This meant the numbers of planned staff did not match with the actual number of staff available to meet the needs of patients. For the night allocations for these dates, the patient had four staff allocated each shift.

Another patient had a prescribed observation level of 5:1. On nine day shifts during May 2020 they were observed by

four staff and on three days only three staff were allocated. There was not a day shift with five members of staff allocated during the whole month. At night, four staff undertook observations on each shift in May 2020.

Another patients' prescribed observation level was for 3:1 staff however; only two staff were allocated on two occasions in May 2020. At night, the patient was allocated two staff for 11 shifts during May 2020.

Another patients' prescribed observation level was for 3:1 staff. During the majority of day shifts in May, two staff were allocated with a third listed as response. There was no cover for breaks listed and staff took hourly breaks between 12-4, which often meant these observations reduced for that period to 2:1. On two occasions in May 2020, only two staff were allocated to observations, and on one of these days only half a page of allocations were completed. On one occasion, at the start of the shift, there were only sufficient staff available to allocate one member of staff for these observations. It was unclear if further staff were arranged as the rota was completed for 1:1 staffing only for half the shift. The remainder of the sheet was not completed at all. During the night, for the same patient, observations were allocated to one staff member for the whole of May 2020.

On seven allocation sheets, a member of staff was identified as the response person, meaning they would assist in other apartments, but given that every staff member on duty was allocated to observations, it was unclear how this would work in practice. In addition to this, staff told us that they were sometimes confused about what their response should be to an alarm as they were already a staff member short on the team they were working in. They told us they did not feel confident or comfortable in leaving the team they were allocated to support another patient as this would leave the team short staffed.

Whilst 19 staff were the minimum number required to facilitate observations, this did not allow for staff meal or comfort breaks, and it was evident from the staff allocation records that staff were often completing entire 12-hour shifts allocated to patient observations.

It was not clear that patients were allocated sufficient amounts of staff to fulfil their prescribed observation level and it was not clear how staff could take breaks from observations without this having a further impact on observation levels.

In May 2020, 209 day shifts were covered by permanent support workers, with a further 351 day shifts covered by bank or agency support workers. Night duties were covered by permanent support workers for 213 shifts, with a further 288 shifts covered by bank and agency staff. Overall this meant that 60% of all support worker shifts were covered by bank or agency staff. Given that a number of patient care plans stated that patients preferred familiar staff, it was unclear how this could be facilitated.

We examined allocation sheets related to one patient and we found that staff were conducting 1:1 or 2:1 observation for at least three hours consecutively without a break and usually for six hours or more and on occasions for up to nine hours. On one occasion, a staff member was with the same patient from 8pm till 11pm then a different patient from 11pm to 2am.

On another occasion, a different staff member was allocated to observe a patient from 11pm to 2am, despite them being assigned to have their break between 1am and 2am. This would not have been possible without leaving the patient without a member of staff.

These examples evidence that the provider was not following national guidance in relation to the use of observation levels. The providers observation policy did not contain guidance about the maximum length of time staff should spend on observations continuously (It was due to be reviewed in March 2020, but this hadn't been undertaken). National Institute for Health and Care Excellence Guidance; Violence and aggression: short-term management in mental health, health and community settings NG10 guidance states providers should, "Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours".

During the inspection we spoke to managers about our concerns in relation to staffing levels. Managers explained that they used a number of different systems to ensure that the correct amount of staff were on duty. These included

day and night rotas for both support workers and qualified nurses and the teams were also supported by a number of additional staff who did not appear on a rota and were not named on any allocation sheets.

Managers also explained that they had introduced a new staffing model which changed the way that staff observing patients would be assigned. Due to the number of different ways of recording staff and through the analysis provided above, we were not assured that the levels of staff could meet the necessary observation levels set out in patients care plans.

Nursing staff

The service had four registered nurses employed at the time of the inspection. This meant that for 46 shifts out of 62 across May 2020, the service had one registered nurse on duty. On 18 of these occasions, (39% of the time) the only registered nurse on duty was an agency nurse. One agency nurse, who was regularly block booked by the hospital, covered 14 of these shifts which offered consistency, but four shifts were worked by different agency nurses each time. This meant these were staff who did not know the needs of patients.

Due to the complex needs of the patient group, for these 46 shifts, the registered nurse may not have been able to take a break as there was no other registered nurse to cover. This could impact on patient safety if the nurse was not properly rested.

Registered nurses were allocated to either the whole hospital or to individual apartments if there were two nurses on duty. Their names were not featured on allocation sheets and it was unclear how their time was planned or what core activities they were required to complete, apart from medication dispensing.

Assessing and managing risk to patients and staff

Assessment of patient risk

A patient's risk management plan (physical aggression section) was last updated on 07/07/2019. It stated, 'no changes necessary'. This did not reflect the increase in incidents involving this patient which demonstrated that the patient's behaviour and presentation had significantly deteriorated since December 2019.

The terminology on a patient START (Short term assessment of risk and treatability tool) risk assessment contained statements including; 'very dishonest', 'attack', 'does not comply', 'does not always obey', 'refuses to co-operate'. These statements are not conducive to the promotion of positive behavioural support planning. This type of terminology does not demonstrate that staff understand the behaviours associated with autism and a person-centred approach or that the patient was treated as an equal by staff. We were concerned as there is evidence that closed cultures can develop with the use of such negative statements from staff which can transfer into negative staff attitudes and behaviours towards patients.

It should be noted that the provider informed us that this assessment should not have been in use any longer, but at the time of the inspection it was available to staff supporting this patient and could have influenced their approach.

Care plans for two patients stated they both communicated primarily using Makaton which is a sign language for hearing people who have communication needs including not using speech to communicate. Of the staff providing direct observations for these patients at the time of inspection, one member of staff told us they were Makaton trained and the others stated they were not. We asked for evidence of training of staff in Makaton and we were provided with an e-mail which stated by the end of May 2020 staff would know 10 basic Makaton symbols. This was not enough to communicate and support patients effectively because the 10 symbols may not be the symbols that the patients use.

When we raised this issue with managers, they told us that the preferred communication methods for both patients were in fact different to that which was documented in the care plans. They did however state that staff were aware of how the patients communicated and that staff supporting them had the necessary skills to do so.

One patient frequently took their clothes off, sometimes in communal areas where there was CCTV in operation, but there was no CCTV care plan in place for this patient.

One patients' physical needs' care plan identified that they experienced epileptic seizures. However; the care plan did not contain clear information about how staff should manage and treat this condition.

We enquired with the management team about the status of this patient's epilepsy and they responded stating that they had not had a seizure since 2010. However, an assessment, completed in March 2020, gave detailed information about seizures as recently as February 2020.

The same patients' physical needs care plan identified the patients had hearing loss but there was no detail of how staff should encourage the patient to use hearing aids or information about whether they needed one or two aids. On the day of inspection, the patient was not wearing hearing aids, they were in the office. Staff said the patient had refused to wear them. There was no strategy for staff to follow in the care plan in relation to encouraging the patient to use them to aid communication with staff. However, we did see evidence that staff had attempted on several occasions to get the patient to wear the hearing aids, and staff had taken the patient to a hospital in an attempt to get the hearing aids repaired.

Their START risk assessment had been completed but significant behavioural risks had not been carried across to care plans. This was important as staff following the care plan may not been aware of the risks and how to respond to these appropriately to mitigate them.

One patient's observation prescription chart dated 25 March 2020 stated it should be reviewed on 6 May 2020 and there was no record it had been. This meant that potentially the patient may have been on a level of observations that was no longer clinically appropriate. This patient also had a communication plan in their file for a different patient who was no longer a patient at the hospital.

Management of patient risk

Staff did not always manage risks to patients effectively.

During inspection, we witnessed a patient deliberately bang their head on the floor, against the wall and against the door causing bleeding from their forehead. Prior to the inspectors leaving the building, managers told us that the qualified nurse had reviewed the patient and that the patient did not require any further medical attention. However, the patients care plan stated that if this type of incident occurred, then staff should seek medical advice or attention. By the end of the inspection, staff had not sought any further medical advice. We spoke to a manager who informed us that they would ensure staff sought medical advice for the patient immediately. Following our inspection, the service confirmed they had sought medical advice for the patient after the inspectors highlighted this to managers.

Staff were not always following advice in the patients care plan about how to interact with them when they were in crisis. For example, the care plan stated the patient responded better with one member of staff taking the lead with communicating with the patient. It also stated that staff should not make eye contact with the patient. However; we observed four staff stood around the patient looking at them and they were making several suggestions, comments and asking the patient numerous questions one after the other when trying to offer support. This meant that the patient remained unsettled for longer than they might have, should staff have followed guidance contained within the care plan.

There were also multiple notes in this patients' file that pain could be leading to their distress, however we did not witness staff exploring the possibility that they may be in pain during the three hours we were in the area.

We were not assured during the inspection that staff were maintaining the privacy and dignity of one patient. The patient was naked for much of the three-hour period we were present on the apartment. The patients care plan identified that they removed their clothing if it got even slightly wet. Immediately prior to the patient removing their clothing, we observed they had spilt water on their clothing from a bottle of water they were drinking from.

When we asked a member of staff caring for the patient if the patient had removed their clothing because it was wet, they told us no it was just something they did. Staff failed to demonstrate they understood or recognised the link between the patient's behaviour of removing their clothing and the trigger for this as identified in their care plan.

Staff told us they were unclear about when they should respond to incidents as they felt conflicted due to their current role on observations and did not want the observation levels of patients, they were supporting to fall below the prescribed level. The allocation sheet which had a space to record which staff should respond to incidents and cover staff breaks was often blank. For apartment 4, of

the 67 hourly allocation sheets we reviewed, 44 (65%) were blank in the response column. Staff told us there were insufficient staff numbers on duty to respond to incidents or cover their breaks.

Another patients' care plan identified the patients dislikes which included a lot of new people. An analysis of staff rotas identified that a large number of different staff were allocated to look after them during the month rather than a steady core team which the patient preferred. This meant the plan of care was not always being followed.

The same patient had a section 17 leave form in their file which stated that staff should carry buccal midazolam (an emergency rescue medication used to stop an epileptic seizure) and staff should be trained to administer this if needed. Records showed that the staff who had taken the patient out on day of inspection had not been trained in the administration of buccal midazolam and therefore it had not been taken out on this episode of leave from the hospital. Failure to administer buccal midazolam at the right time can lead to more serious long-term medical problems such as brain injuries.

Staff access to essential information

The CCTV monitoring system had recently been up-graded to include a process where it could now be viewed externally by a manager via a weblink. We raised a safeguarding alert following a whistleblowing allegation that someone other than staff had observed live footage of a patient who was naked. The manager confirmed they alone had access remotely to the CCTV. Following our inspection, the service told us a visiting safeguarding team had observed footage on a CCTV engineers' laptop. The policy did not describe how footage should be accessed and stored.

The CCTV policy had not been updated to reflect the change in practice and we were not assured that it was effective in guiding staff to ensure that patients' privacy, dignity and confidentiality was protected at all times.

In one patients file, the Care and Treatment review was dated October 2015, however, staff told us there was a more recent review that had taken place. This meant that not all staff had access to the most up to date information in relation to the patients care and treatment, which could lead to confusion or a lack of a shared vision or direction for the patients care. Following our inspection, the service told us that historical records had been added to the current records so that any gaps in treatment plans could be revisited using previous records.

Medicines management

Staff did not follow good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did not do this in line with national guidance.

The provider medicines policy (version 2) did not provide guidance for staff in managing medicines safely. It did not reflect or reference legislation or best practice guidance, including consideration of the Mental Health Act, Mental Capacity Act and controlled drugs legislation.

The only guidance referred to within the policy was the Nursing and Midwifery Council (NMC) guidance from 2004, on page 16. The NMC updated this guidance several times before withdrawing all specific medicines management guidance for nurses in 2019.

Throughout the policy, there was no reference to the Mental Health Act and aspects of medicines management relating to treatment under the Act, provisions when patients were not consenting or lacked capacity and provisions under the Act for second opinions. The policy included a statement that, "the service user has the right to refuse their medication and can do so at any time" (section 12.1). There was no reference to staff administering treatments authorised under the Mental Health Act. The policy referred to suitable trained professionals administering medication, whereas this should refer to registered nurses for patients detained under the Mental Health Act.

Guidance on medicines errors did not link to consideration of safeguarding actions (section 18). Therefore, we were not assured that when medication errors occurred that due attention would be given to any possible safeguarding concerns that these errors might raise.

The policy was the responsibility of the registered hospital manager and the head of clinical care. However; there was no registered manager and no head of clinical care within this service at the time of the inspection.

The policy included reference to verbal instructions (section 19) including the need for this to be witnessed,

recorded correctly and confirmed in writing. We noted on a prescription card two prescriptions for PRN (as required) medication which had been completed by a registered nurse following a telephone instruction from the doctor. There was no evidence that this had been witnessed. Section 19.11 outlined that written confirmation by email or fax must be received within 24 hours and stored with the medication card and that this must be in place before medicines were administered. These instructions had been in place for six weeks without being re-written or reviewed by medical staff. In total 12 doses of medication had been administered without a legal prescription.

The policy included a section (section 20) on controlled drugs. The guidance did not sufficiently guide staff in the storage and administration of controlled drugs. It referred to care assistants, whereas this service employed registered nurses and support workers. The legislation quoted did not include The Controlled Drugs (Supervision of Management and Use) Regulations 2013.

Appendix 4 of the policy was a consent form for patients wishing to have their medication "disguised". A relative or appointee signature was requested on the form, "if the service user is unable to consent". This does not reflect the guidance relating to covert medication and the Mental Capacity Act, which states that a relative or appointee cannot consent on another's behalf.

Appendix 5 was a support worker competency assessment despite the policy not explicitly referring to support workers administering medicines anywhere within it. Appendix 9 was a flowchart outlining levels of administration indicating that support staff could undertake level 1 and 2 tasks, including oral medicines, inhalers, topical preparations, eye, nose or ear medications. However, this appendix was not referred to within the policy

We looked at one patient's prescription to specifically review their treatment for a condition. We noted a number of concerns relating to prescribing, administration and medicines errors. The provider medicine policy stated that all prescriptions should have an allergy status completed, yet both prescription charts for this patient that we reviewed had the box left blank. The provider policy stated that medications should not be administered if allergies are not stated (part 11.14) yet the patient had been administered medication for over two months from this prescription.

A patient was prescribed an antidepressant. From their administration record there were three doses on consecutive nights in April 2020 with a "U" suggesting unavailable, although it was available for morning doses on two of those days. Therefore, the dose was given on the two mornings but not on the three nights. It was unclear why or how this error occurred. Following our inspection, the service informed us a staff member had used an incorrect code on the medication record (the medication was available, but the patient had been asleep, so the nurse had not given the prescribed medication).

Two PRN (as required) prescriptions were completed by a nurse indicating verbal authorisation over the telephone in April 2020. One of the prescriptions was for a medicine also prescribed as a regular dose but no instructions were given in relation to this. Neither of these had been reviewed by a prescriber since and up to the inspection these prescriptions were still being used with 12 medication doses having been given by nurses.

Track record on safety

Reporting incidents and learning from when things go wrong

An entry staff made in a patients' care record to record an incident, referenced that the patient had attempted to bang their head however; it failed to record that they had sustained an injury as a result of their head banging which had resulted in them bleeding from the head or that their injury had been reviewed by the registered nurse who made a judgement that no action was necessary.

In addition, the handover notes for the evening did not include any detail about this incident. This meant that there was no evidence that on coming staff had been informed of the incident involving the patient and the head injury they had sustained as a result of this and any action staff needed to take in relation to this. Following our inspection, the service told us that handover notes were prepared in advance (and thus might not always be up to date), and that staff coming on duty would have been verbally informed of such incidents.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they meet the communication needs of all patients.
- The provider must ensure that medicines are managed safely.
- The provider must ensure that measures are in place to ensure that staff understand and follow each patients' care plan.
- The provider must ensure that there are sufficient staff to carry out observations safely and in line with each patients' care plan.
- The provide must ensure that the terminology used in care plans promotes good practice, a positive culture and is person centred.
- The provider must ensure that governance systems are effectively facilitating reviews of practice and policy, that policies remain up to date and that staff are adhering to such guidelines.

Action the provider SHOULD take to improve

- The provider should ensure that all staff are clear who will carry out essential tasks relating to the safety of the wards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing