South West London and St George's Mental Health NHS Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQY08	Tolworth Hospital	Jasmine ward	KT6 7QU
RQY01	Springfield University Hospital	Crocus ward	SW17 7DJ

This report describes our judgement of the quality of care provided within this core service by South West London and St George's Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South West London and St George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St George's Mental Health NHS Trust.

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

- Working age adults were being admitted to the wards for older people. This compromised the safety of patients. There had been serious incidents on Crocus ward involving younger adult patients.
- The wards for older people did not comply with guidelines for gender separation. Some patients had to walk through communal areas to reach the bathroom, which compromised their privacy and dignity.
- Staff carried out a visual check on patients' skin integrity when they were admitted to the wards. They did not carry out a formal assessment of risk of developing a pressure ulcer for every patient. This was contrary to trust policy.
- Staff had left patient related information unattended in a ward dining room;
- Patient observation records were not always completed or were completed retrospectively;

However, staff carried out assessments of patients' risk of falls and put plans in place to address the risks identified. Staff managed medicines safely. The ward environments had been adapted to make them more suitable for patients with dementia. There were sufficient staff to care for patients safely. Staff had been encouraged to report all incidents. Consequently, there had been an increase in the number of patient falls reported by staff.

Staff assessed patients' needs and put care plans in place to address the needs identified. Patients had good access to physical health care. Several staff had completed specialised training in dementia care. Staff received regular supervision and most had completed an annual appraisal. Multi-disciplinary teams worked well together on the wards.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

- Working age adults were being admitted to the wards for older people. This compromised the safety of patients. There had been serious incidents on Crocus ward involving younger adult patients.
- The wards for older people did not comply with guidelines for gender separation. Some patients had to walk through communal areas to reach the bathroom, which compromised their privacy and dignity.
- Staff carried out a visual check on patients' skin integrity when they were admitted to the wards. They did not carry out a formal assessment of risk of developing a pressure ulcer for every patient. This was contrary to trust policy.

However, staff carried out assessments of patients' risk of falls and put plans in place to address the risks identified. Staff managed medicines safely. The ward environments had been adapted to make them more suitable for patients with dementia. There were sufficient staff to care for patients safely. Staff had been encouraged to report all incidents and there had been an increase in the number of patient falls reported by staff as a result.

Are services effective?

Staff assessed patients' needs and put care plans in place to address the needs identified. Patients had good access to physical health care. Several staff had completed specialised training in dementia care. Staff received regular supervision and most had completed an annual appraisal. Multi-disciplinary teams worked well together on the wards.

However, staff had left patient related information unattended in a ward dining room. Patient observation records were not always completed or were completed retrospectively.

Summary of findings

Information about the service

The older people's wards provided inpatient services to older adults with organic mental health conditions such as dementia and other forms of cognitive impairment and also patients with functional mental health problems such as psychosis, depression and anxiety. Some patients were detained under the Mental Health Act 1983 (MHA), some had a Deprivation of Liberty Safeguards (DoLs) authorisation in place and some patients were admitted informally.

During the inspection we visited:

Jasmine ward, a 17 bed ward for older adults at Tolworth Hospital. There were 13 patients admitted to the ward on the day of our inspection.

Crocus ward, a 21 bed ward for older adults at Springfield University Hospital. There were 16 patients admitted on the day of our inspection.

Our inspection team

The team that inspected the older people's service consisted of an inspection manager, and two inspectors.

Why we carried out this inspection

We inspected this service to find out whether the trust had made improvements in older people's inpatient wards since our last inspection in March 2014.

In March 2014 we had been concerned about inconsistent risk assessment of patients. When risks had been identified staff had not always taken action to manage those risks, this particularly related to falls risk assessments. Incidents were not always being reported and patient care plans were not detailed or personalised. We also had concerns about the separation of male and female patients on Azaleas ward at Tolworth Hospital (now closed).

These concerns were inspected as part of this focussed inspection. We found improvements had been made and the requirements had been met. However, we identified other concerns or the same concerns on different wards during this focussed inspection.
We made two requirement notices where there had been breaches in regulations.

How we carried out this inspection

In order to follow up the areas of concern we had identified in March 2014 we concentrated on two key questions:

- Is it safe?
- Is it effective?

Before the inspection visit we reviewed information that we held about the service.

During the inspection visit the inspection team:

- visited two older people's wards and looked at the quality of the ward environment;
- spoke with five patients admitted at the time;
- spoke with a carer;
- spoke with senior managers;
- spoke with 19 staff working in the wards including nurses, OT, dietician, and consultant psychiatrist;
- looked at ten care and treatment records of patients;
- observed how staff were caring for patients;
- conducted a period of structured observation on each ward;

Summary of findings

- attended and observed a handover between the morning and afternoon shifts;
- looked at a range of records, policies and documents relating to the running of the service.

What people who use the provider's services say

We spoke with five patients and one carer on the two wards. In addition we carried a period of structured observations of interactions between patients and staff on each ward.

One patient reported how calm staff were even when patients were distressed. Patients spoke positively about staff and felt safe on the ward. Staff had time to talk to patients and relatives. A relative told us they were involved in their family member's care and felt their views were taken on board. Patients said they were seen regularly by the doctor and felt listened to. They felt fully involved in decision-making about their care and treatment. One patient told us they had seen other patients falling and said the doctor always attended promptly to help them. Patients thought the wards were clean. A carer told us the ward had a lovely atmosphere.

There were mixed views on the meals provided. One patient said it was horrible whereas others said the food was good and there was always a choice. Patients had access to drinks when they wanted one and staff encouraged patients to drink. There were also mixed views on the quality of activities provided. One patient said they were too simplistic while someone else said they were good and met their needs.

We saw staff supporting patients in a sensitive, friendly manner and taking time to talk with relatives. The atmosphere in the wards was very comfortable and the patients spoke with staff and others openly and in a relaxed manner. Staff were very caring and spent time with patients individually. They gave patients time to express themselves and do things for themselves. They provided calm reassurance when patients were distressed.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the older people's wards do not provide beds for working age adults who are not clinically appropriate for a service for older people.
- The provider must ensure that the wards for older people comply with guidelines for gender separation.

Action the provider SHOULD take to improve

- The provider should ensure that a 'Waterlow' assessment is completed for every patient on admission, in line with trust policy.
- The provider should ensure that all confidential patient records are stored securely and not left unattended on the wards.
- The provider should ensure that all staff complete patient observation records contemporaneously and in full.

South West London and St George's Mental Health NHS Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Jasmine ward	Tolworth Hospital
Crocus ward	Springfield University Hospital

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in and had good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Several patients had DoLS authorisations in place. Where emergency authorisations had been granted the service had applied for and received a regular authorisation. A trust audit of consent and capacity practice carried out from January – March 2015 reported that most records on Jasmine ward demonstrated good practice.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

- Working age adults were being admitted to the wards for older people. This compromised the safety of patients. There had been serious incidents on Crocus ward involving younger adult patients.
- The wards for older people did not comply with guidelines for gender separation. Some patients had to walk through communal areas to reach the bathroom, which compromised their privacy and dignity.
- Staff carried out a visual check on patients' skin integrity when they were admitted to the wards. They did not carry out a formal assessment of risk of developing a pressure ulcer for every patient. This was contrary to trust policy.

However, staff carried out assessments of patients' risk of falls and put plans in place to address the risks identified. Staff managed medicines safely. The ward environments had been adapted to make them more suitable for patients with dementia. There were sufficient staff to care for patients safely. Staff had been encouraged to report all incidents and there had been an increase in the number of patient falls reported by staff as a result.

Our findings

Safe and clean environment

- None of the bedrooms had en-suite facilities and patients used shared bathrooms and showers. On Jasmine ward there were separate corridors for female and male bedrooms. Both corridors were accessed by using a code which provided a level of security. Patients were given the code to their specific corridor. However, on another corridor joining the male and female corridors to the communal areas of the ward and the front door there were four additional bedrooms and a bathroom that patients in those rooms could use. There were two female patients using those bedrooms at the time of our visit. In order to reach the bathroom the two female patients needed to use a corridor being used by both men and women to access the other bedrooms or the day room. This meant the layout of the ward did not comply with guidance on same sex accommodation and compromised patients' privacy and dignity.
- On Crocus ward most patient bedrooms were separated according to gender. The male and female bedroom areas were on opposite sides of the ward and had their own dedicated bathrooms. However, there were two bedrooms on a separate corridor, termed flexi-beds by staff. At the time of our visit there was one female patient using a flexi-bed. This area did not have a dedicated bathroom or toilet. To reach the female bathroom the patient in the flexi-bed needed to walk across the communal day room. This meant the layout of the ward did not comply with guidance on same sex accommodation and compromised patients' privacy and dignity.
- There were fully equipped clinic rooms on both wards. Records showed that the emergency equipment was regularly checked and maintained by staff.
- Ward areas were mostly clean and well maintained. Patients told us the wards were always clean. A patient led assessment of the care environment (PLACE) had taken place on Jasmine ward the week before our visit. The results were not yet available but the matron told us some improvements were needed. These included removal of dust from under some beds and high areas of the ward. During our visit to the ward we noted the toilet next to the quiet room in the corridor had dust on the walls and appeared to need cleaning. The chart on the wall that recorded when the toilet had last been checked and cleaned showed that it had not been since Monday, two days before our inspection.
- The ward environments had been adapted to make them more comfortable for older people some of whom had dementia or other types of cognitive impairment. Thought had been given to patients' needs. Contrasting colours were used to help patients. Colour and contrast can be used to help people with sight loss and dementia to identify key features and rooms. On Jasmine ward there was good signage with photographs that helped patients identify their bedrooms.

Are services safe?

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- All the rooms on Jasmine Ward had a nurse call system so that when a patient required assistance staff could respond.
- Jasmine ward had an attached garden that was accessible to patients.
- A ligature risk assessment had been carried out on Crocus ward in October 2014. No high risk ligature points had been identified. Where risks had been identified there were plans in place to manage these safely. A ligature risk report for Jasmine ward dated January 2015 identified a number of ligature risks on the ward and the actions being taken to remove them.
- On Jasmine ward showers were automatically activated. Staff said this made some patients reluctant to use the showers as it made them difficult to use and ensure the temperature of the water was hot enough from the start. There were no taps on wash basins as a safety measure. Water was turned on by pushing a button which staff said some patients found confusing.
- Medicines were managed safely. Medicines were stored in locked cabinets in the clinic room on both wards. Each patient had a medicine administration record that included their photograph to aid identification. We reviewed medicine administration records and found gaps in the administration records of two patients on Jasmine ward. One patient record had been signed showing that medication for the following day had been administered. We raised this matter with the nurse in charge who immediately rectified the situation.
- The pharmacist regularly checked all the records and highlighted any missing signatures. When medication was omitted staff used a code to record the reason why. Medication that was required on an 'as needed' basis was recorded separately. There were clear instructions describing the circumstances when this would be used. If 'as needed' medication was being used regularly there was evidence that this was reviewed by the clinical team.

Safe staffing

- There were sufficient staff on the wards to care for patients safely. Ward managers were able to bring in additional staff to cover any shortages or if the needs of patients changed. Safe staffing levels and the number staff on duty on the day were on display in the wards. On both wards there were five staff on duty during the day (three qualified nurses and two unqualified) and four (two qualified nurses and two unqualified) at night. The ward was not full and this was sufficient to meet patients' needs. Staffing levels were scrutinised daily by matrons and at the trust daily staffing meeting. The safe staffing level report for the first half of April showed that Jasmine ward had always met agreed levels. There had been a slight shortfall on Crocus ward although we noted that the ward had not been at full capacity and there were several empty beds.
- Records of safe staffing levels on Jasmine ward from February to April 2015 showed that an average of 99% of qualified nurse shifts had been filled during the day. At night the picture was similar with over 100% of qualified nurse shifts filled on average over the three month period. All health care support staff shifts had been filled during the day and at night.
- Crocus ward records of safe staffing levels February to April 2015 showed that an average of 79% of qualified nurse shifts had been filled during the day and 97% of shifts at night. The number of health care support staff shifts filled had been over 100% both during the day and at night.
- Ward performance reports of the period from January to March 2015 showed that Jasmine ward had a staff sickness rate of 3% whilst on Crocus ward this was higher at 12-15%. Staff turnover in the last six months had been quite high on both wards. On Jasmine ward it was reported to be 24% and on Crocus ward it was more than 30%.
- There was regular use of bank and agency staff on Jasmine ward to maintain safe staffing levels. There were three staff vacancies on Crocus ward. Two vacancies were for nurses and the third for a health care support worker. Staff had been recruited to two of these posts and were undergoing pre-employment checks.
- The trust had implemented a daily staffing meeting which was chaired by the head of nursing. A daily staffing report was sent to all matrons and ward managers. This meeting kept an overview of staffing levels across the trust. Any unfilled shifts were escalated in order to provide cover.

Are services safe?

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- Staff reported that the newly introduced trust staff bank was unable to provide staff at short notice, for example, when a staff member was sick. They felt the previous system had been much more responsive.
- Staff had received, and were mostly up to date with mandatory training. The performance dashboard on display in Jasmine ward showed that 84% of staff were completely up to date with training requirements in April 2015.

Assessing and managing risk to patients and staff

- Staff had recorded 158 falls on Jasmine and Crocus wards in 2014/2015. The reporting of falls on the older people's wards had increased significantly between the second and third quarters of 2014, from an average of seven falls per month to 22 falls per month. This was in response to a greater emphasis on recording falls. The number of falls reported in quarter four fell to an average of 9.5 falls being reported monthly. This followed initiatives to reduce the number of falls including better falls risk assessment and care planning.
- Trust audits of the completion of falls risk assessments showed an improving picture on Jasmine ward where 100% of patients in quarter three had a falls risk assessment on admission. The number of patients who had a falls care plan in place to address identified risks was 71% in quarter three. On Crocus ward the completion of falls risk assessments between June and December 2014 was 65% and 83% of patients at risk of falls had a falls care plan in place.
- We reviewed the records of ten patients on the two wards and saw that a risk assessment was undertaken on every patient when they were admitted to the ward. These included falls risk assessments. Risk assessments were updated regularly or after an incident had occurred if this was sooner. Where risks were identified plans were put in place to manage the risk and keep patients safe. Risk summaries were completed for all patients whose records we checked.
- Those patients at higher levels of risk were clearly identified so that all staff were aware of their needs.
- Staff carried out a visual examination of the condition of patients' skin when they were admitted. Any marks, redness or bruising were recorded on an individual body map. However, staff did not routinely use a recognised tool, a Waterlow assessment, to formally assess patients' risk of developing a pressure ulcer. Only if a patient's presentation suggested they were at risk of skin breakdown or developing a pressure ulcer would staff complete the Waterlow assessment form. This was contrary to the trust's physical health care and disability policy which stated that a Waterlow assessment must be completed for every patient on admission.
- Patient records showed that pressure relieving mattresses and cushions were obtained for patients assessed as being at risk of a pressure ulcer. Care plans were in place to ensure staff knew how to manage the risk effectively and prevent skin breakdown. There had been three incidents of pressure ulcers reported on the two wards in 2014/2015. Two of these incidents related to the same patient. Two of the incidents were classified as hospital acquired pressure ulcers.
- Regular observational checks were carried out on patients. The levels and frequency of checks varied depending upon the needs of each patient.
- Younger adults were sometimes admitted to both of the older adults' wards when there was no bed available in the acute wards. There had been 32 patients under the age of 60 years admitted to Crocus ward since 31/10/2014. Eight of these patients had been under 26 years of age. Seven patients were admitted directly to the ward rather than to an acute bed first. In the same time period six patients aged less than 60 years had been admitted to Jasmine ward. Two of these patients had been under 25 years of age. One patient was admitted directly rather than to an acute bed first.
- On Crocus ward there had been two serious incidents in the previous three weeks, both involving adults under the age of 45 years. One incident had involved a serious assault by a newly admitted younger patient on an older person admitted to the ward. The incident was under investigation. In the second incident a younger patient had harmed themselves very seriously. Staff were very concerned about the impact of younger, acute, patients being admitted to the older patients ward and the risks this posed to patients.
- The consultant psychiatrist on Crocus ward told us he did not have clinical responsibility for younger age patients admitted to the ward. Any younger age patients admitted to Crocus ward on a Friday were not clinically

reviewed by the responsible home team until the following Monday. The inappropriate admission of younger patients to the inpatient wards for older people posed a clear risk of harm to patients. Care and treatment was not being provided in a safe way to patients.

- Staff knew how to safeguard patients from possible abuse. Staff we spoke with had all received training in safeguarding adults and knew how to recognise a safeguarding issue. In the ward handover staff discussed a referral that had just been made to the local safeguarding team following an allegation of financial abuse.
- Medicines were managed safely. Medicines were stored in locked cabinets in the clinic room on both wards. Each patient had a medicine administration record that included their photograph to aid identification. We reviewed medicine administration records and found gaps in the administration records of two patients on Jasmine ward. One patient record had been signed showing that medication for the following day had been administered. We raised this matter with the nurse in charge who immediately rectified the situation.
- The pharmacist regularly checked all the records and highlighted any missing signatures. When medication was omitted staff used a code to record the reason why. Medication that was required on an 'as needed' basis was recorded separately. There were clear instructions describing the circumstances when this would be used. If 'as needed' medication was being used regularly there was evidence that this was reviewed by the clinical team.
- On Crocus ward senior staff checked medicine administration records on every shift to ensure there were no missing signatures or reasons why a medicine was not given.

Track record on safety

- There had been two serious incidents on Crocus ward in the last two weeks. There had been a recent death of a patient admitted to Jasmine ward which was being investigated.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. There was evidence of increased reporting of falls in response to greater encouragement to complete incident reports appropriately.
- Incidents were discussed at clinical governance meetings.
- There was evidence of learning from incidents. Immediate changes had been made to ward processes following a serious incident on Jasmine ward. Other learning had occurred following a medicines incident. Staff had been provided with additional training in order to prevent a reoccurrence. In October 2014 learning events on diabetes and falls had been held for staff to support improvements in care and treatment.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Staff assessed patients' needs and put care plans in place to address the needs identified. Patients had good access to physical health care. Several staff had completed specialised training in dementia care. Staff received regular supervision and most had completed an annual appraisal. Multi-disciplinary teams worked well together on the wards.

However, staff had left patient related information unattended in a ward dining room. Patient observation records were not always completed or were completed retrospectively.

Our findings

Assessment of needs and planning of care

- Patients' needs were comprehensively assessed when they were admitted to the ward. A full physical examination was carried out. The performance dashboard on display in Jasmine ward showed that 91% of patients had a physical health assessment on admission. The trust target was 95%.
- We reviewed the care plans of six patients; three patients on each ward. Care plans were in place that addressed patients' assessed needs. Care plans were personalised and covered patients' mental as well as physical health needs, such as diabetes. The consultant on Crocus ward had delivered practice development sessions to staff on how to complete the national early warning signs (NEWS) chart used to record patients' vital signs. NEWS helped identify when a patient's condition might be deteriorating and a doctor needed to be informed. We saw that regular checks of patients' blood pressure and pulse were recorded on patient NEWS charts.
- Most information needed to deliver care effectively was recorded appropriately and stored securely. However, we found a trolley containing patients' physical health care records left open and unattended in the dining room on Jasmine ward. In addition we found records of observations of patients were not being completed contemporaneously. We observed staff completing observation sheets at the end of the morning shift. There were several gaps in recording. For example, for one patient on level two observations, within eyesight, there was a period of four hours when records had not been completed. For another patient on level two observations there was no observation recording sheet available or being used.

Best practice in treatment and care

- Policies and procedures gave reference to the national guidance they were based on. This ensured assessments and interventions were evidence based. Staff followed National Institute for Health and Care Excellence (NICE) guidelines on supporting people with dementia and their carers. The trust's falls prevention and bone health policy had been updated and brought in line with NICE guidelines and NPSA rapid response guidance.
- Patients had access to good physical health care. Patients were referred to a range of different health professionals including a podiatrist, speech and language therapist, physiotherapist, and dietician when this was appropriate to their needs.
- Patients' nutrition and hydration needs were assessed and addressed. Patients had access to drinks throughout the day and staff offered and encouraged patients to drink. The service operated protected meal times which meant patients should not be disturbed while they were eating. Where there were concerns about patients eating and drinking they were referred to a dietician. A dietician told us staff were good at referring patients and did so appropriately. They said staff were good at completing food and fluid charts when this was required and weighed patients every week. This was confirmed by records we reviewed.
- A real time electronic feedback machine was situated in the wards. This allowed patients and carers to provide feedback about the service. The service responded to feedback from patients and carers and made improvements. For example, patients on Jasmine ward had asked for medicines to be given earlier. In response morning medicines were reviewed by the medical team and prescriptions were spread across the day.

Skilled staff to deliver care

- There were a range of different disciplines working in the teams. This included occupational therapists,

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occupational therapy assistants, nurses, health care assistants, consultant psychiatrist and junior doctors. All staff, patients and carers we spoke with on Jasmine ward praised the work and enthusiasm of the activity co-ordinator.

- We carried out periods of structured observation on both wards. We saw that staff were skilled in the way they delivered care to patients. They were kind and compassionate and responded in a very caring way to patients who were distressed. They spoke with patients at eye level. They did not restrict patients' movement around the wards unnecessarily but ensured patients remained safe. They took time to engage with patients on an individual basis.
- All staff were due to undertake a three day training course in dementia. The course was being provided by a local university. Eight staff from Crocus ward and five staff from Jasmine had completed the training since December 2014. Staff had received bespoke training in how to restrain an older person safely. Additional training in physical health concerns was planned and was also being delivered by a local university. Some staff had already completed this. The three day course was provided twice a year and was being gradually rolled out to all staff. The training helped to ensure that staff had the skills to care for older people effectively.
- Staff received individual supervision every month. Staff told us supervision usually took place as planned. Staff told us they had received an appraisal in the last year. The quality and performance tracker for April 2015 for Crocus ward showed that 85% of staff had received an annual appraisal. Records showed that on Jasmine ward 86% of staff had received an annual appraisal.
- All new staff received an induction which included the model of care and how to support the needs of their patient group. Staff also had a period of shadowing other staff before taking on their full responsibilities. The Crocus ward manager had shadowed the modern matron for two weeks when she commenced in her role.
- Staff were offered support after serious incidents occurred.

Multi-disciplinary and inter-agency team work

- The multi-disciplinary teams worked well together.
- Staff described good relationships with other services. The ward consultant was also a consultant in the community team which helped maintain continuity of care after the patient was discharged.
- The dietician monitored the weights of referred patients, organised meal replacements, reviewed the menus and advised on allergies. The physiotherapist undertook falls risk assessments and ensured appropriate walking aids and foot wear were available to reduce the risk of falls.

Good practice in applying the Mental Capacity Act

- Staff were trained in and had good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Several patients had DoLS authorisations in place. Where emergency authorisations had been granted the service had applied for and received a regular authorisation.
- A trust audit of consent and capacity practice carried out from January – March 2015 reported that most records on Jasmine ward demonstrated good practice.

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 Patients were not always treated with dignity and respect. The layout of both wards for older people meant that the wards did not comply with guidance on same sex accommodation and compromised patients' privacy and dignity. This was in breach of regulation 10(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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way to patients. Acute adult patients received care and treatment on the older people's wards when this was not always clinically appropriate. This posed a clear risk of harm to older patients. This was in breach of regulation 12(1)