Derbyshire Healthcare NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

Cubley Court male
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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)
RXM 14		Cubley Court male	DE22 3LZ

This report describes our judgement of the quality of care provided within this core service by Derbyshire Healthcare NHS Foundation 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 Derbyshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Derbyshire Healthcare NHS Foundation Trust.

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

Contents

Summary of findings

Overall summary

We only looked at parts of the three questions at this inspection that related to the concerns raised. These were:

- Is it safe?
- Is it effective?
- Is it well led?

We did not rate the service at this inspection as we only inspected one ward and looked at specific issues relating to the concerns we had received.

We found the following issues that the service provider needs to improve:

- Staff completed patient observations but did not always record these.
- Staff had not reported an incident or their concerns in a timely way to ensure patient safety.
- Staff did not always update assessments following incidents or changes to patients' needs.
- Staff did not always assess and record appropriately decisions made about patients who had impaired mental capacity.
- Bank staff did not have access to all the training and supervision that permanent staff had. The ward had not had a permanent manager for over 18 months which had impacted on staff morale.
- Work had not been completed to improve the ward to enhance the experience of patients living with dementia.

However, we also found the following areas of good practice:

- The ward was clean and the provider ensured that equipment was regularly serviced.
- Managers supervised and appraised permanent staff.
- The multi-disciplinary team worked well together to care for the needs of the patients.
- Staff interacted with patients in a caring and compassionate way.
- Improvements were being made to the way that staff cared for patients to prevent them from falling.

Summary of findings

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

Are services safe?

We found the following issues that the service provider needs to improve:

- Staff did not always record patient observations which could impact on the patient's safety.
- Staff had not reported an incident to the local authority safeguarding team in a timely way to ensure the patient's safety.
- Staff had not reported an incident on the electronic incident reporting system in a timely way to ensure the patient's safety.
- Established staffing levels needed to be reviewed daily to meet the complex needs of the patients.

However, we also found the following areas of good practice:

- The ward was clean and staff followed infection control principles.
- The provider made sure that equipment was regularly serviced by an engineer so that it was safe to use.
- Staff completed risk assessments and took action to reduce the risks to patients safety.

Are services effective?

We found the following issues that the service provider needs to improve:

- Staff completed assessments of patients' needs on their admission to the ward. However, staff did not always update assessments and care plans following incidents or changes to the patient's needs.
- Staff could not always access the electronic patient records in a timely way so the records showed the actual care delivered to the patients.
- Relationships with the local authority safeguarding team had not been effective.
- Staff had not always assessed and recorded appropriately capacity to consent for patients who might have impaired capacity.

However, we also found the following areas of good practice:

- Staff had effective working relationships with other teams within the trust.
- Managers supervised and appraised all permanent staff.
- Patients had access to good physical healthcare including a range of specialists.

Summary of findings

- Staff from a range of mental health disciplines provided care and treatment to patients.

Are services caring?
Not inspected.

Are services responsive to people's needs?
Not inspected.

Are services well-led?
We found the following issues that the service provider needs to improve:

- Staff reported that the morale on the ward was low due to there not being a permanent ward manager for over 18 months.
- Staff told us that they felt able to raise concerns without fear of victimisation. However, they had delayed in reporting a concern.
- The provider had reported that they had completed a recommendation made at a previous inspection about improving the environment for patients living with dementia. However, we saw that this work had not been completed.

However, we also found the following areas of good practice:

We saw a quality improvement project that was piloted on the ward and improvements were being made to prevent patients from falling.

Summary of findings

Information about the service

Cubley Court is a 36-bedded assessment and treatment unit for both men and women with an organic illness, such as dementia who require a period of assessment. There is one ward for men (Cubley male) and one ward for women (Cubley female).

We undertook an inspection of this core service which included Cubley Court male ward in January 2017 following the comprehensive inspection in June 2016. We rated the core service as Requires Improvement following the inspection in January 2017. The concerns from that inspection that specifically related to Cubley Court were:

- The trust had not provided staff at Cubley Court with the specialist training they needed to care for patients.
- Staff at Cubley Court had not completed all records relating to patients' physical healthcare needs.
- The environment at Cubley Court was not fully adapted to meet the needs of patients living with dementia.
- Managers did not supervise all staff regularly.

We undertook a Mental Health Act review at Cubley Court male in August 2017. This found:

- Assessments of mental capacity varied in detail
- There were limited interactions between staff and patients
- The hospital did not have a system in place to alert them to the expiration of urgent authorisations of Deprivation of Liberty Safeguards.
- Staff lacked understanding in terms of the Independent Mental Capacity Advocate role.

Our inspection team

The team comprised four CQC Inspectors and one Assistant Inspector.

Why we carried out this inspection

We carried out this unannounced inspection due to receiving information of concern following a serious untoward incident. We were informed by the local authority safeguarding team that a patient had fallen and was not taken to the acute general hospital until two days after. The provider did not report the incident to the local authority until twelve days later after the patient had died. We focused our inspection on Cubley Court male ward only as the concerns related to there to see if this was a systemic issue or an isolated incident. The concerns were raised around staff, their training and action taken following incidents.

How we carried out this inspection

This inspection was unannounced. We have not rated the ward. We looked at parts of the three domains where concerns had been raised and asked:

- Is it safe?
- Is it effective?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited Cubley Court male ward and looked at the quality of the ward environment and observed how staff were caring for patients

Summary of findings

- spoke with two relatives of patients who were using the service
- spoke with the manager for the ward
- spoke with nine other staff members; including nurses, occupational therapists and doctors
- looked at four treatment records of patients
- carried out a specific check of the incident management
- looked at a range of policies, procedures and other documents relating to the running of the service
- carried out Short Observational Framework for Inspection (SOFI) observations
- observed part of the handover between early and late shift and one multi-disciplinary meeting

What people who use the provider's services say

The people who used the service were unable to tell us their experience due to their communication needs.

Relatives said that staff were wonderful and supportive. They said that staff cared well for their relative who always looked clean and well dressed. They said that staff informed them if their relative had fallen or was unwell. One relative said that staff treated people with dignity.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff record all patient observations in a timely manner to ensure patients safety.
- The provider must ensure that staff complete all records about patients in a timely manner to ensure patients' needs are safely met and that electronic systems support this.
- The provider must ensure that all staff fully complete Mental Capacity Act documentation and assessments. The provider should also ensure that all staff apply the Mental Capacity Act correctly and that they fully understand how it relates to the patient group that they are caring for.

Action the provider SHOULD take to improve

- The provider should review the established staffing levels and increase where needed to meet the complex needs of the patients now admitted to the ward.
- The provider should provide more training in dementia to staff so they have the skills to meet the needs of all patients.
- The provider should complete the work to improve the environment at Cubley Court so it is fully adapted to benefit patients with dementia.

Derbyshire Healthcare NHS Foundation 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
Cubley Court male	Trust HQ

Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had trained staff in the Mental Capacity Act (MCA).
- Staff had not always assessed and recorded appropriately capacity to consent for patients who might have impaired capacity.
- Staff had recorded for one patient that a decision was made in the best interests of the patient as they lacked capacity. However, this was not specific to each decision being made.
- There were arrangements in place to monitor adherence to the MCA within the Trust.

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

Our findings

We did not look at all aspects of the safe domain at this inspection.

Safe and clean environment

- Staff were not able to observe all parts of the wards. It was not possible to observe bedrooms from the main corridor. Staff reduced the risks by observation and risk assessment.
- The provider had completed ligature risk assessments which were last updated on 23 January 2018. A ligature risk assessment is a document that identifies places to which patients intent on self-harm might tie something to strangle themselves. The provider completed these for each room on the ward and identified the action to be taken to reduce the risks. Staff had also completed individual risk assessments where patients were at risk of self-harm.
- Cubley Court had separate wards for men and women and therefore complied with the guidance on same sex accommodation. We only visited Cubley Court male at this inspection.
- We did not look at the clinic room at this inspection as this was not part of the concerns raised.
- There was no seclusion room and staff did not use this intervention.
- Housekeeping staff were cleaning the wards during our inspection. The ward was clean and was well maintained.
- Hand gel was available for staff to use in the reception and ward areas as part of infection control principles and we observed staff using the gel.
- The provider had made sure that an engineer had regularly serviced hoists and bathing equipment so that it was safe for patients to use.
- We did not look at cleaning records at this inspection as this was not part of the concerns raised.
- Staff completed risk assessments of the ward environment. We saw that these were last reviewed a month before our inspection. If there was an identified area of concern there were action plans put in place to reduce or remove them.
- Staff carried alarms to respond to emergencies and incidents. We observed that staff responded quickly when the alarms were sounded.

Safe staffing

- The provider and managers assessed the number of nursing staff required on the ward based on the clinical need of the patients, as well as bed occupancy. However, staff told us that the current staffing levels did not meet the complex needs of the patients admitted to the ward. The community Dementia Rapid Response Team had reduced admissions but this meant that the needs of patients admitted were more complex and higher staffing levels than established were needed. We spoke with trust senior managers who were aware of this. The provider had secured funding for an activity worker and a nurse clinical lead who would be additional to the nursing staff. These posts had been advertised to help to reduce the impact of the staffing shortfall on patients. The provider had recently recruited two healthcare assistants. This meant that there would be no vacancies for the established posts.
- Rotas showed that there were two registered nurses and five nursing assistants on each of the early and late shifts during the day. At night there were two registered nurses and four nursing assistants. This met the planned staffing hours. However, due to the observation levels that patients needed to keep them safe, an additional staff member was needed on each shift. Staff told us that the high level of observations that several patients were on had an impact on how they could support patients who were not on observations. The provider did not use agency staff but its own bank staff to cover. The acting ward manager told us that they requested bank staff in advance as it was difficult to cover at short notice. The provider told us that in the four weeks before our inspection the number of shifts covered by

bank staff had ranged from 48 to 75 each week. Managers tried to use regular bank staff wherever possible to help promote continuity and consistency of care.

- In addition to nursing staff there was a senior occupational therapist, an occupational therapist and occupational therapy assistant based at Cubley Court. The acting ward manager and a lead nurse were also additional to the rota. On the day of our inspection, one staff member had phoned in sick so the lead nurse was not additional but worked as part of the staffing numbers.
- Senior and lead nurses were able to adjust staffing levels daily to meet the needs of patients. On each day shift there was a bleep holder who was always based on the ward as an additional staff member. At night there was a coordinator on the site who assessed the need to move staff around wards if needed. Staff told us that the coordinator reviewed the risks on each ward before moving staff around.
- We observed that a registered nurse was available in the communal areas of the ward at all times.
- Staff told us that there was inadequate medical cover night and day, so that a doctor could always attend the ward quickly in an emergency. They said that doctors were not always available at night. Staff said that they had to wait over four hours for a doctor to see a patient who was admitted at night. The consultant said they had formally raised their concerns with the provider about the lack of consultant input on wards in the south of the county. There were currently six consultants when there should have been eight. The consultant told us that the provider had responded and job plans were being looked at to rectify this.
- Staff had received and were up to date with mandatory training.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment of every patient on admission. In three patients records staff had updated this regularly and after every incident. However, in one patient's records staff had not updated their risk assessment following an incident where the patient fell.
- The provider had a policy on the observation of patients. This detailed the levels of observation needed to keep patients who were a risk to themselves or others safe. Staff were aware of what level of observations individual patients needed and this information was passed over to the next shift during handover. Observation levels were assessed and reviewed in line with the policy. Staff recorded details of observations onto the PARIS system (electronic patient records). Staff said this system was difficult to use and would stop working about once a week which caused delays in inputting information and impacted on time they spent with patients. We observed that staff wrote down their observations on pieces of paper for the registered nurses to put these details onto the system retrospectively. Staff had not completed one patient's electronic observation charts on one day for six hours in the morning and a further two hours in the evening. The patient was recorded as being on level two observations which meant that they should have been within eyesight of the staff member allocated to observe them. The observation policy stated that this was "required when a patient could at any time make an attempt to harm themselves or others". On another day when they were on level two observations, staff had not completed their records for one hour and later for five hours. However, staff had recorded level three observations instead which is "checks every 15 minutes - intermittently and not on each 15 minute." Staff had not recorded two observations for another patient who was on level two observations on one day. For a third patient who was on level two observations during the day, staff had not recorded four observations on one day and one the next day.
- Staff used SCIP (Strategies for Crisis Intervention and Prevention) to manage patients when they behaved in a way that was agitated or aggressive. This is an approach that aims to minimise the use of physical interventions and instead emphasise behaviour support strategies which are based upon an individual's needs characteristics and preferences. The provider trained all staff in this and in yearly updates. Staff told us they used distraction techniques if patient was unsettled, such as, taking the patient to a quieter area to give them more space, music, sing along or a walk outside if appropriate for the patient.
- The provider trained all staff in safeguarding adults who may be at risk from abuse. Staff we spoke with were aware of the provider's policy on safeguarding and knew

how to make a safeguarding alert. However, staff had not made a referral to the local authority safeguarding team for an incident where a patient was at risk of harm. The provider was investigating why staff had not done this. The provider had suspended a bank staff member pending investigation following concerns raised.

Track record on safety

- The local authority safeguarding team informed us that the provider had not reported an incident where a patient had fallen until 12 days later. Managers had met with staff on the ward to discuss the importance of raising concerns and given staff again details of how to contact the trust Freedom to Speak up Guardian. Managers invited all staff to debrief them the week before our inspection. Managers told us that staff felt that they had not always been supported when they had raised concerns. They were offering additional support and supervision to staff, confidential support was available to all staff in trust and managers had made occupational health referrals for some staff. The provider had an action plan that detailed action to be taken to reduce the likelihood of this happening again. We will continue to monitor progress on this and liaise with the local authority safeguarding team.

Reporting incidents and learning from when things go wrong

- Staff spoken with said they knew what to report and how to report. However, staff had not reported using the online incident reporting system an incident involving a patient until three days later. The trust incident policy stated that an incident form should be completed within 24 hours of an event. This was the same incident as reported above where there was a delay in reporting to the safeguarding team. We saw that this incident was reported in the handover from night to day staff but an incident form was not completed. Staff had reported 21 other incidents about this patient on the online incident reporting system. Managers told us that they had reviewed incident reporting processes and a staff member from the incident reporting team had visited the ward to help increase the confidence of all staff to report.
- A relative told us that staff were open and transparent and explained to them when things had gone wrong. They had been informed of an incident involving their relative and what action was taken as a result. They said that staff always phoned them when their relative had fallen and told them of any action taken.
- We observed a multi-disciplinary meeting of professionals involved with patients. This included discussion about specific incidents and what changes the provider needed to make to improve patient safety.

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.

Our findings

We did not look at all aspects of the effective domain at this inspection.

Assessment of needs and planning of care

- We saw evidence in four care records that staff completed timely assessments with the patient and their relatives where appropriate on admission to the ward.
- Care records showed that staff undertook a physical examination of each patient on admission and continued to monitor the patients' physical health problems. However, one patient had fallen but staff had not updated their falls care plan until three days later. Staff had also not updated the patient's pain assessment after the patient had fallen. Staff had started to complete a nutrition assessment for another patient but had not completed it.
- Records showed that staff had completed detailed care plans with the patient and their relatives/carers where appropriate. The multidisciplinary team reviewed the care plan during meetings with the patient.
- Information needed to deliver care is stored securely. However, it was not always available to staff in an accessible format when needed. Staff told us that the electronic patient records system did not support the care delivered to patients as staff had to record on paper and the nurse would input to the system later in the shift. Staff told us they had raised this with the provider.

Best practice in treatment and care

- Staff told us that managers led teaching sessions on the National Institute for Health and Care Excellence (NICE) guidance. This included doctors, registered nurses and healthcare assistants. As a result of this falls were identified as a high risk area for the ward and the falls project was started. They now had a weekly falls meeting that involved all professionals who worked with the patient. At this meeting they reviewed the patient's medication and their bone health. Staff said this helped to increase their skills and gave them a better understanding of the patient's needs.
- Records showed that patients had good access to physical healthcare; including access to specialists when needed.
- Staff assessed patients' nutrition and hydration needs. A dietitian was linked to the ward and gave advice to staff where needed. We observed that staff assisted patients who were unable to feed themselves. Staff said and we saw that staff recorded patients food and fluid intake on paper first and then transferred this to the electronic paper records system.Staff said this could cause errors in recording of what a patient had eaten and drank which could impact on their health. Staff had reported these issues to the provider but no changes to the system had been made.

Skilled staff to deliver care

- The full range of mental health disciplines and workers provided input to the ward. This included occupational therapists, physiotherapists and psychiatrists.
- The provider gave an induction to permanent staff when they started working there. The acting ward manager was not sure if bank staff had a formal induction. They planned to make sure that new bank staff working on the ward would have an induction to the ward and the needs of patients. One bank staff said the provider had trained them when they first started working there.
- Two staff members we spoke with were not clear about what training they had in dementia awareness and said they needed more training to better meet the needs of the patients.However, following our inspection the provider sent information about e-learning dementia awareness training for staff at Cubley Court male. This showed that 36 of 38 staff who were eligible to receive dementia awareness training at level one had done so. 11 of 12 staff who were eligible to receive dementia awareness training at level two had done so. The provider also told us that consultant psychiatrists and the trust dementia specialist provided all staff with training about different types of dementia. The provider showed us training materials used about different types of dementia that included the rarer forms. Records did not show that bank staff had training in dementia.
- Managers supervised and appraised all permanent staff.Staff had access to regular team meetings. Bank staff did not have supervision.

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.

- The percentage of non-medical staff that had an appraisal in the last 12 months was 100%.

Multi-disciplinary and inter-agency team work

- There were regular and effective multi-disciplinary meetings. We observed a review meeting where the needs of three patients were discussed. The team included a consultant psychiatrist, nurses, social worker and the trust practitioner for restrictive practices. The team also discussed the input of the speech and language therapist, physiotherapist, tissue viability nurse and pharmacist in the care of the patient.
- We observed part of an effective handover between the early to late shift. However, we looked at handover records for three days. On two days these lacked detail and it was not clear who had completed them. On the other day more detail was recorded but it was unclear who had completed it and which shift it referred to.
- Records showed and we observed there were effective working relationships including good handovers with other teams in the organisation. This included the community Dementia Rapid Response Team.
- Relationships with the local authority safeguarding team had not been effective. However, following our inspection the safeguarding team manager told us that the provider had requested to meet with them to discuss how they could improve this.

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

Not inspected.

Good practice in applying the Mental Capacity Act

- The provider's records showed that 94% of staff had completed training in the Mental Capacity Act.
- For people who might have impaired capacity, capacity to consent was not always assessed and recorded appropriately. One patient's records included five assessments of the patient's capacity to make a decision. One was specific to the decision being made and included assessment of all the principles of the Mental Capacity Act. However, staff had not completed all parts of the other four assessments. For example, for one assessment, it was not clear what decision the assessment was based on. On another assessment, staff had not fully answered whether or not the patient could weigh and retain the information needed to make the decision. In another patient's record, one capacity assessment had two decisions on one assessment. Each assessment should be specific to one decision. Staff had not recorded on two assessments how they had reached the decision that the patient did not have the capacity to make the decision.
- One patient's record showed that decisions had been made in the best interests of the patient as they lacked capacity. However, this was not specific to each decision being made but applied to all decisions.
- There were arrangements in place to monitor adherence to the MCA within the trust. The trust mental capacity lead did spot checks of capacity assessments. We saw these for the ward for October and November 2017 and January 2018 and these showed improvements had been made. They noted that the standard of entries in records of capacity to consent in electronic patient records by junior doctors had improved. The provider's actions were to continue to support and train all staff and provide further encouragement to junior medical staff to promote better quality free text entries.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

Not inspected.

The involvement of people in the care that they receive

Not inspected.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge
Not inspected.

The facilities promote recovery, comfort, dignity and confidentiality
Not inspected.

Meeting the needs of all people who use the service
Not inspected.

Listening to and learning from concerns and complaints
Not inspected.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

We did not look at all aspects of the well-led domain at this inspection.

Vision and values

Not inspected.

Good governance

- The provider used key performance standards to gauge the performance of the team. The acting ward manager was aware of the standards and the performance of the staff team in meeting these. They reported the performance to the fortnightly managers meeting.

Leadership, morale and staff engagement

- Staff we spoke with told us they felt able to raise concerns without fear of victimisation. The local authority safeguarding team made us aware of an incident where staff had delayed in reporting concerns. The provider was investigating why staff had not reported these concerns. In response to this delay, they held weekly staff meetings on the ward to make staff familiar with the provider's policy on raising concerns and who to go to. They had also asked the trust Freedom to Speak up Guardian to visit the ward and increased staff supervisions. Staff said this had helped them to feel supported by the provider.
- All but one staff member we spoke with told us that the morale on the ward was low. They said this was due to not having a permanent ward manager for over 18 months. The ward manager post had been filled by several temporary appointments. However, the current ward manager, who was a senior experienced nurse, had been acting in post for the last six months to provide stable leadership. Staff told us the acting ward manager was responsive, open to other professionals' comments and actively empowered staff to do their job and make decisions. The provider told us that the recruitment process had not been successful but they had secured funding for this post and had been advertised so they hoped to have a permanent ward manager in post. Following this inspection, the provider informed us that this post had been recruited to and they were due to start in May 2018.
- Staff told us that the senior leadership of the trust had improved and efforts had been made to improve communication with staff.

Commitment to quality improvement and innovation

- At our last inspection in January 2017, we told the provider that they should improve the environment so that it was fully adapted to meet the needs of patients living with dementia. We looked at the providers records at this inspection which stated that this action was completed in September 2017. We noted that dementia friendly signage was provided on toilet doors. Staff told us that further work was requested in November 2017 to replace fireplaces to create a more homely environment. The ward was designed so that patients could walk around which helped to reduce the frustration of closed doors. However, there were no items around the walls for patients to touch, feel and engage with on walls and places to stop to rest. This would enhance the environment for people living with dementia in line with national guidance and research. Following our inspection, the provider told us that these had been purchased.
- The falls prevention lead and moving and handling adviser told us about the falls prevention and management quality improvement project. This had been piloted on the ward since November 2017. It started with a team away day to see what was needed. From this they now have a specific falls multi-disciplinary meeting for each patient. We observed a meeting which included input from the pharmacist, named nurse, doctor, occupational therapist, physiotherapist and falls lead. When staff report on the electronic incident reporting system that a patient has fallen this automatically goes to the falls lead. They oversee what action has been taken to prevent the patient from falling again. They told us this has helped to prevent further falls. They visit the ward to inform staff where changes are needed to patient care so that this information is not lost in the electronic system.

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
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not always carry out mental capacity assessments in a consistent way.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not record observations of patients in a timely way. Staff did not complete all assessments of patients.