Cygnet (OE) Limited

Cygnet Wast Hills

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

Following the inspection, we served the provider with a Letter of Intent under Section 31 of the Health and Social Care Act 2008, to inform them of our immediate concerns and warn them of possible urgent enforcement action. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within 24 hours that described how it was addressing our concerns. Due to the serious nature of the concerns we found during this inspection, we used our powers under Section 31 of the Health and Social Care Act 2008 to issue a Notice of Proposal. The proposal is to impose conditions on the providers registration through a Notice of Decision. However, at the time of publication the provider had the opportunity to make legal representations against the Notice of proposal.

Our rating of this location went down. We rated it as inadequate because:

- The service did not always provide safe care. The environment required attention in some areas. The service had enough nurses and support workers in the Main House and the Annexe, although there were not enough staff deployed in the Lodge to safely meet the needs of the patients living there.
- Staff did not always adequately assess and manage patients' physical health particularly after incidents of self-harm such as head banging or nursing interventions, such as rapid tranquilisation, in line with national guidance. Records were not completed consistently or were missing which put patients at further risk of harm.
- Incidents were not being recorded consistently either in the patient care record or on the providers incident reporting system, and some were not being recorded at all. Not all staff had full access to the incident reporting system and did not always receive feedback.
- Not all staff were adhering to the provider's high-level nursing observation policy and we were not assured staff had the relevant skills, competencies and training to do so. Some patients had incidents of self-harm whilst being observed by staff.
- Medicine policies were not always followed correctly. Staff did not ensure medicines were always administered on time.
- There was a lack of meaningful activity or occupation to keep patients engaged. All patients had an activity plan which was individualised, however staff were not proactively engaging patients in activities and structured activity plans were not always followed.
- Governance processes were in place, however they did not always operate effectively to ensure that patients were safe, and performance and risk was managed well. Governance records were not fully completed locally. We were not assured that all staff followed and understood the provider's policies and protocols.

However:

- Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- The ward teams had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability and autism and in line with national guidance about best practice.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- Staff planned and managed discharge well and liaised with services that would provide aftercare. However, discharges were delayed due to reasons beyond the provider's control.
- Staff felt respected, supported and valued and most staff enjoyed working for the provider and understood how their vision and values applied in the work of the team.

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

Professor Ted Baker

Chief Inspector of Hospitals.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	The summary is contained in the overall summary at the beginning of the report. Our rating of this service went down.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Wast Hills

Wast Hills House is an independent hospital providing assessment, treatment and care to people with a complex learning disability and autism. It is managed by Cygnet. The site has three units, the Main House, the Annexe, and the Lodge. They have a total of 25 beds: 15 in the Main House, six in the Annexe and four at the Lodge. Whilst we were on inspection there were 13 patients admitted: nine in the Main House, two in the Annexe and two in the Lodge. Some patients in the Main House and the Annexe have 'bespoke' areas which have been created for their individual needs and provided them with more room to move about. One patient was in long term segregation.

Wast Hills House is registered with the Care Quality Commission for the following regulated activities:

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

Treatment of disease, disorder or injury

Both the Main House and The Lodge are period properties, and the Annexe is a single-story purpose-built unit. The hospital is set in six acres of ground in a rural location in Worcestershire.

The service is commissioned through clinical commissioning groups. The Care Quality Commission were processing the registered manager's application and was still pending when we inspected. Wast Hills admission criteria states that patients must have a dual diagnosis of learning disability and autism.

We carried out this inspection because we had concerns about the care and treatment provided at Wast Hills. We had received concerns from commissioners, advocacy and several complaints from a family member. These concerns comprised of poor communication, lack of activities, lack of involvement in multidisciplinary meetings and patient injuries.

Commissioners had raised their concerns with the provider about the care and treatment of their patients prior to our inspection.

The independent advocacy service had raised concerns regarding access to patients during the height of the COVID-19 pandemic. However, at the time of the inspection, processes were in place to allow statutory services to visit and maintain safety.

What people who use the service say

People told us they felt safe, and staff were available to help them when they needed them. They said there were enough staff to help them, and they were kind. Patients felt happy at Wast Hills, and staff were available to talk to whenever they wanted. They felt included in their care and were asked what they wanted to do.

Family members were happy with the care provided although some thought that communication could be improved.

Summary of this inspection

How we carried out this inspection

This was an unannounced comprehensive inspection.

We were on site for four days. A combination of five inspectors, one medicine inspector and a specialist advisor were on site for some or all four of these days. An expert by experience carried out telephone interviews with family members.

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information. During this inspection, the inspection team:

- Interviewed 33 staff members,
- spoke with four patients,
- interviewed two senior managers,
- looked at the quality of the hospital environment,
- looked at eight patients' care and treatment records,
- spoke with six family members,
- completed a series of short observational framework for inspection assessments,
- looked at other documentation and records related to patient care and overall governance of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with four legal requirements.

- The service must ensure that all ward environments are properly maintained. (Regulation 15 (1)(a)(e))
- The service must ensure that all areas are adequately staffed at all times. (Regulation 18 (1))
- The service must ensure that patients are provided with and engaged with meaningful activity to aid recovery. (Regulation 12 (1)(2)(b))
- The service must ensure that all staff undertaking high level nursing observations have the relevant skills, competencies, and training to do so, and do so in line with the provider's engagement and observation policy and protocol. (Regulation 12(1)(2)(c))
- The service must ensure that patients physical health is monitored appropriately when required following incidents of self-harm, in line with the provider's policy. (Regulation 12(1)(2)(b))
- The service must ensure that physical health monitoring post administration of medicines to manage violence and aggression are completed according to national guidance and the providers policy. (Regulation 12(1)(2)(g))
- The service must ensure that medicines policies and procedures are always adhered to. (Regulation 12 (1)(2)(g))
- The service must ensure that all incidents are recorded in the provider's incident reporting system. (Regulation 17(1)(2)(b)(c))

Summary of this inspection

- The service must ensure that there is sufficient oversight of the service to ensure quality and safety of patients is monitored and maintained and that staff have awareness and adhere to the provider's policies and procedures. (Regulation 17(1)(2)(a))

Action a provider SHOULD take is to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that staff adhere to the provider's COVID-19 policy regarding wearing face masks. (Regulation 12)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Requires Improvement	Good	Good	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Good	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Furnishing across the site was of good quality and was well maintained. The environment was sparse and bare, although this was in line with the low stimulus philosophy of the service and to aid people with autism spectrum disorder. However, some areas of the environment required attention. Some areas of high use such as communal doors or where maintenance had taken place required painting, skirting boards were broken in places and paint was chipped. The registered manager had a plan to make improvements to the environment and was waiting for this to be approved.

The environment looked clean in most areas although there was what appeared to be a faeces smear on the sink in the Annexe.

Staff did not always comply with the provider's COVID-19 infection control policy and national guidance. Staff took daily COVID-19 tests and used hand sanitisers provided at the hospital. Adjustments were made to carry out patient handovers in two large, ventilated rooms. However, three staff were either not wearing a mask or not wearing it appropriately. Staff did not change masks when moving to different sites across the hospital.

There were not enough registered nurses across the hospital to keep patients safe from avoidable harm. On the 10 May there were three qualified nurses and 28 un-qualified support workers for the day shift and two qualified and 22 unqualified support workers for the night shift. The service required 27 staff to cover high level nursing observations during the day. This allowed for one unqualified to float between staff on nursing observations and attend to the needs of the patients.

The service had a staff establishment of 100 unqualified staff. There were 69 support workers in post with vacancies for 31. Managers interviewed for staff every week. Bank and agency staff were used to cover vacancies. Between 26 April and 9 May agency use averaged at 42% per day. However, 70% of these agency staff did regular shifts and were knowledgeable about the service and the patients.

Staff turnover was 40% since November 2020. Managers said staff had left for various reasons but were confident that the new staff they had recruited were of good quality.

The policy for high level observations for that site stated that staff did not have to make any record of the observation, unless the patient's individual commissioning team requested this. Five patients' observations were recorded whilst we were on site. We were not assured that managers could be certain that patient observations were being completed appropriately, if there was no record of the task. This meant that we could not be assured that patients safety was always maintained.

Some patients continued to harm themselves despite having completed risk assessments and during high level nursing observations. Three patients had harmed themselves on more than one occasion whilst on high level nursing observations.

There were patients at the service who headbanged. One patient had incidents of headbanging on a regular basis. Between 4 March and 10 May, they had 41 such incidents. The patient had been able to head bang in the toilet whilst we were on inspection. Staff increased their level of observations to prevent them from doing this again, however when we looked in their patient care record, we saw that they had done this on three occasions in the toilet previously and nursing observations had not been increased, because the multidisciplinary team had not provided guidance to remove toilet privacy.

Staff responded to alarms across the site. However, the Lodge was a two-minute walk away from the main buildings which could cause a delay in the response which meant there was potential risk to both staff and patients whilst waiting for help to arrive.

Three staff were concerned that there were not enough staff at the Lodge. There were two patients who were on high level nursing observations and two support staff. Staff said it was difficult at times to meet patients' needs as they were unable to leave them due to being on nursing observations.

There were enough staff to provide nursing observations. One or two staff were available to float across the buildings. However, staff said there was not always a float on shift which meant there wasn't always someone available for staff to take breaks.

The high-level nursing observation policy for that site stated that staff did not have to make any record of the observation, unless the patient's individual commissioning team requested this. Two patients' observations were being recorded whilst we were on site. We did not see staff engaging patients in meaningful activity whilst on observations, mostly they were observing the patient. One patient was inside their room with the door closed and staff were outside where they could not observe them. We were not assured that managers could be certain that patient observations were being completed appropriately, if there was no record of the task. This meant that we could not be assured that patients safety was always maintained.

Most staff we spoke with were knowledgeable about patient needs. They could describe patients' likes and dislikes and knew how to care for them safely. However, some agency staff were not always familiar with specific care plans, however communication grab sheets and positive behavioural support plans were available. Some staff did not understand patients and could not effectively communicate with them, which meant they could not anticipate their needs.

We looked at the provider's incident record from 3 March to 10 May 2021. Three safeguarding referrals had been made internally although no further action was deemed necessary.

Some of the patient's records were kept in separate files from each other. For example, prescription records were separated from physical health records. Agency staff had no direct access to electronic records, which also included

some medicine behavioural care plans. The *when required* protocols for people's medicines to manage behaviour were kept on the electronic system and not with the prescription charts for use by all staff. This meant there was no visible plan in place for managing a patient's behaviour that linked with the medicines prescribed by the provider. This was promptly rectified by the provider.

The service used systems and processes to prescribe, administer, record and store medicines, however, they were not always managed well.

Most patients had received the correct medicines at the right time. However, some patient's prescription charts showed a broad range of time in which the medicines were able to be administered. This could have resulted in medicines being administered at varying time intervals, which meant, they could have been given too close together or too far apart. Patient's medicines were regularly reviewed to monitor the effects of medicines on their health and wellbeing. Staff followed systems and processes to safely record and store medicines.

The provider was unable to provide the specific physical health monitoring records for a patient administered intra-muscular medicine to manage their behaviour. This was administered according to their own prescription records on twelve occasions. This was a requirement according to national guidance on managing violence and aggression and the provider's own rapid tranquilisation policy. We were not assured that the provider was completing physical health monitoring after rapid tranquilisation.

Some staff were not following the rapid tranquilisation policy correctly. Some staff attempted to monitor patient's physical health when they received oral *when required* medicines. The policy did not state that this was required. However, records for this were inconsistently completed, even though staff thought this was a requirement within the rapid tranquilisation policy. This meant staff were not adhering to the correct physical health protocols following rapid tranquilisation, meaning patients were at risk of potential harm.

The service had not always managed patient safety incidents well. Staff did not always report incidents appropriately. Managers investigated incidents, although we were not assured that all incidents were being recorded. When things went wrong, staff apologised and gave patients honest information and suitable support.

We looked at the provider's incident report from 3 March to 10 May 2021. Six patients had episodes of headbanging and there had been 86 incidents of this type during that time. We saw that for 20 incidents, patients had some physical observations taken, but staff had only completed the Glasgow Coma Scale observations for 11 patients, otherwise known as neurological observations. This was not in line with NICE CG176 Head injury: assessment and early management guidance.

We looked in detail at two patients care notes to see if staff had completed and recorded neurological observations following episodes of head banging. One patient had 12 episodes of headbanging between 13 April to 13 May. Staff had only recorded one instance of neurological observations being taken during this time. The other patient had seven episodes of headbanging; no neurological observations had been taken and recorded.

Not all incidents were being recorded appropriately in line with the provider's policy. For example, one patient had an episode of self-harm which was recorded in the patient care record, however it had not been recorded on the incident report. Whilst we were on inspection, we witnessed a patient being physically restrained. This had not been recorded in the patient care record when we looked two days later. A further episode of aggressive behaviour for the same patient had also not been recorded in the incident report.

Inadequate

Wards for people with learning disabilities or autism

All staff had access to the incident system to record an incident, however only senior staff had access to that incident report once it had been recorded, although they could review a summary of incidents raised and had access to an incident dashboard. Staff told us they did not always know of the outcome of the incident following a manager's review. The service had reported 330 incidents from 3 March to 10 May 2021. Not all staff received feedback regarding these incidents.

Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Staff undertook relevant assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

Staff were generally knowledgeable about physical health, and care plans were in place for specific needs. However, there was a lack of clarity amongst the staff team regarding a patient with epilepsy. Four staff we spoke with had differing opinions regarding their epilepsy diagnosis. We found it difficult to find care plans for one patient with epilepsy, however the provider later sent us the care plan.

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Positive Behavioural Support plans were in place for all patients which were easily accessible and easy to follow.

All patients had an individualised activity plan which they helped to develop with the occupational therapy team. The provider monitored levels of activity and all patients were expected to do at least 25 hours. This included activities of daily living, relaxing or watching TV and meaningful activity such as sports, trips out in the car or arts and crafts.

However, we observed a lack of meaningful of activities. Many patients were relaxing, watching TV and lying on the sofa. Most staff confirmed that patients did not always engage in meaningful activities. Staff were not proactively engaging patients in activities and structured activity plans were not always followed, especially when patients did not want to participate.

Staff agreed that meaningful activity was lacking. Managers had engaged in a project to improve engagement between staff and patients whilst on high level nursing observations. The purpose was to increase engagement through activity, which should decrease incidents as patients were occupied in meaningful tasks which they enjoyed.

Staff used recognised rating scales to assess and record severity and outcomes.

Inadequate

Wards for people with learning disabilities or autism

The ward team included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005 and discharged these well. People's Mental Health Act documents were kept with the relevant prescription charts for staff to check before administration of their medicines. Managers made sure that staff could explain patients' rights to them.

People were supported to make decisions about their care. Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Standards. For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions. For example, we saw best interest decisions and inclusion of appropriate medicines administration advice for the covert administration of medicines to a patient.

Are Wards for people with learning disabilities or autism caring?

Good

Our rating of caring went down. We rated it as good.

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with four patients. They said they felt safe and staff were available when they needed them. They all said they had been able to go out when they wanted and there were enough staff to help them. We observed positive and caring interactions between staff and patients.

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

We spoke with six family members. Most thought that their loved ones were being treated well, staff were kind, helpful and knew the needs of the patients.

Carers said they had a weekly update from managers, but some had more regular contact if they wished.

However, two were not happy with the communication they received from the provider and within the service. This related to visiting the service and being able to contact staff on the telephone. One carer did not think that complaints were taken seriously, and their concerns had not been dealt with, although another carer thought that their concerns had been dealt with quickly and efficiently.

Inadequate

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. However, there were at least seven patients whose discharge had been delayed. The patients required an individualised, bespoke package of care which had to be commissioned by the local clinical commissioning group. These placements often had to be tailor made for each patient and this caused a significant delay to discharge.

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

The food was of a good quality and patients could make hot drinks and snacks at any time.

The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Staff developed communication grab sheets which were easily accessible for staff and easy to follow. Not all patients could verbalise their needs. Staff used a variety of methods to communicate effectively with patients such as Makaton, Picture Exchange Communication System and social stories. Staff described the individual communication preferences of patients and how they understood their needs.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are Wards for people with learning disabilities or autism well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leaders had the right skills, knowledge and experience to perform their roles. There had been a big turnover of managers in the previous 12 months and both staff and managers told us the service had felt unsettled. The current manager had been at the service for six months and was an experienced manager and had worked within Cygnet for several years.

Staff agreed that meaningful activity was lacking. This included support workers, members of the multidisciplinary team and managers. Managers had engaged in a project to improve engagement between staff and patients whilst on high level nursing observations. The purpose was to increase engagement through activity, which should decrease incidents as patients were occupied in meaningful tasks which they enjoyed.

Inadequate

Wards for people with learning disabilities or autism

Governance processes did not operate effectively at ward level and that performance and risk was not always managed well. We were not assured that there was sufficient oversight of the service and local governance records for the service were not fully completed. However, there were regional governance processes in place to support the service, and monthly meetings to discuss performance alongside other regional services took place. We looked at four records ranging from October 2020 to March 2021. We saw that month to month comparisons of patient physical restraints, seclusion and long-term segregation, lessons learned and duty of candour, and safeguarding information was not recorded consistently. This meant that the service could not be assured that they were performing effectively or could easily identify areas that required improvement. her similar services correctly. However, the service had consistently monitored areas such as staff training and supervision, patient outcome measures, areas of best practice, complaints and recruitment.

We were not assured that all staff had sufficient awareness of policies and procedures. For example, physical health policies such as rapid tranquilisation and neuro observations policy had not been followed correctly.

Effective systems and processes were not in place to ensure all incidents and safeguarding incidents were reported, and opportunities for lessons learnt were missed. This meant there was no assurance that patients were being kept safe from avoidable harm.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Staff were complimentary about the local managers. They described good, supportive leadership and the manager was approachable. Staff worked well as a team and when there had been problems, they had been quickly rectified.

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

We reviewed the latest staff survey results for the provider. Results showed a significant increase in satisfaction in all areas; staff enjoyed working for Cygnet, felt part of a team, had a comfortable workload and were proud to work for the provider.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service should ensure that medicines policies and procedures are always adhered to. (Regulation 12 (1)(2)(g))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The service must ensure that all ward environments are properly maintained. (Regulation 15 (1)(a)(e))

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service must ensure that all areas are adequately staffed at all times. (Regulation 18 (1))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that patients physical health is monitored appropriately when required following incidents of self-harm, in line with the provider's policy. (Regulation 12(1)(2)(b))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that patients are provided with and engaged with meaningful activity to aid recovery. (Regulation 12 (1)(2)(b))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

- The service must ensure that physical health monitoring post administration of medicines to manage violence and aggression are completed according to national guidance and the providers policy. (Regulation 12(1)(2)(g))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that all staff undertaking high level nursing observations have the relevant skills, competencies, and training to do so, and do so in line with the provider's engagement and observation policy and protocol. (Regulation 12(1)(2)(c))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that all incidents are recorded in the provider's incident reporting system. (Regulation 17(1)(2)(b)(c))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that there is sufficient oversight of the service to ensure quality and safety of patients is monitored and maintained and that staff have awareness and adhere to the provider's policies and procedures. (Regulation 17(1)(2)(a))