Vision MH Ltd

Vision MH - Cornerstone House

Inspection report

Barnet Lane
Elstree
WD6 3QU
Tel: 02089532573
www.visionmentalhealthcare.co.uk

Date of inspection visit: 08 and 09 April 2021
Date of publication: 28/06/2021

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?	
Are services caring?	Inadequate
Are services responsive to people's needs?	
Are services well-led?	Inadequate

Summary of findings

Overall summary

This was an unannounced focused inspection, undertaken due to a high number of notifications (27) received by the Care Quality Commission (CQC) in relation to patients self-harming and requiring hospital treatment.

We did not look at all key lines of enquiry during this inspection. However, the information we gathered provided enough information to make a judgement about the quality of care and to re-rate the provider. Therefore, we have reported on the following domains:

- Safe
- Caring
- Well Led

Cornerstone House was last inspected in October 2017. The service was rated good for effective and responsive, and outstanding for safe, caring and well-led. The service was rated as outstanding overall.

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

- Staff did not always treat patients with compassion and kindness or respect their privacy and dignity. They had not always involved patients and families and carers in care decisions.
- Staff did not always respond to patient's healthcare needs in a timely way. Staff did not always ensure that physical health observation (NEWS) recordings were taken on a weekly basis in line with hospital requirements.
- Staff did not always ensure that physical health recordings were taken following the administration of rapid tranquillisation, in line with the provider's policy, and national guidance.
- Staff did not always record incidents in the patient's daily clinical record or update the patient's risk assessment to reflect identified patient risk. This meant staff did not have the most up to date information about patients' risk and how to provide care to keep patients safe. Therefore, staff had not always taken action to reduce identified risks following incidents.
- Staff did not have access to the risk register and were unaware of its contents.
- Staff did not always take actions to keep patients safe after self-harm incidents. Patient observations were not always reviewed after incidents. Patients' to access items which they could use to self-harm (including items such as crochet hooks, pens and batteries), were not always reviewed on a risk basis.
- Four patients told us they felt it was "*not worth making a complaint*"" as managers did not respond or take action to prevent re-occurrence. Managers did not have an effective process in place to manage patient complaints. When patients made complaints about how staff treated them, the complaint was not formally investigated and only resolved through a conversation with the patient. The managers did not have a way to record if the complaint had been upheld, not upheld or partially upheld. This meant learning from complaints could not take place to prevent re-occurrence.
- There was an out-of-date manual patient resuscitator in the emergency bag, this was equipment required for emergency life support.
- Staff did not always involve patients in writing care plans.
- Staff mandatory training in two skill areas was not up to date.
- The provider had not ensured adequate governance oversight to manage identified clinical risks. Managers had not acted to appropriately address ongoing patient self-harm incidents, medication errors and identified patient risks. Managers had not undertaken a thematic review of patient self-harm or medication errors.

However

Summary of findings

- The hospital environment was clean. The service had enough nurses and doctors.
- The service worked to a recognised model of mental health rehabilitation. Staff provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation service. They offered two streams of psychological treatment pathways; one for patients diagnosed with a personality disorder and the second for patients with a psychosis. The ward service included or had access to the full range of specialists required to meet the needs of patients on the wards.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. Patients and staff could meet with members of the senior leadership team to give feedback.

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.

Ted Baker

Chief Inspector Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Vision MH - Cornerstone House

Vision Healthcare is registered to provide inpatient treatment for people with a mental health diagnosis who may also be detained under the Mental Health Act 1983. It is a high dependency inpatient rehabilitation unit. The service provides assessment, treatment and a recovery-based approach, which is delivered from a multidisciplinary team.

The location inspected is called Cornerstone House. The service accepts males and females.

Cornerstone Hospital is a large, detached house with an additional annex within the grounds. There are several facilities available including a library, multi-purpose room, therapy studios and grounds.

At the time of our inspection, there were 23 patients at the service. The service was registered in January 2011. Regulated activities at this location are:

• Treatment of disease, disorder or injury.

• Assessment of medical treatment for persons detained under the Mental Health Act 1983.

• Diagnostic and screening procedures.

The hospital had a Registered Manager and Nominated Individual in place. However, immediately after the inspection, senior staff told us the Registered Manager had left the service and a new Registered Manager had been identified. This meant the new manager was required to submit an application to CQC to become Registered Manager.

How we carried out this inspection

This inspection was an unannounced, focused inspection of Cornerstone House, undertaken due to a high number of notifications (27) received by the Care Quality Commission (CQC) in relation to patients self-harming and requiring hospital treatment.

We did not look at all key lines of enquiry during this inspection. However, the information we gathered provided enough information to make a judgement about the quality of care and to re-rate the provider. We have only reported in the following domains:

- Safe
- Caring
- Well-Led

Before the inspection visit, we reviewed information from the service about the self-harm incidents that had occurred. We also reviewed feedback information we held about the service from patients and staff (including whistle-blowing concerns).

Summary of this inspection

This inspection took place on the 8 and 9 April 2021. Following the inspection, we served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to 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 they would address our concerns. Their response provided enough assurance they had acted to address immediate concerns.

Inspection Team

One inspection manager and three inspectors conducted this inspection.

Over the two days of inspection, our inspection team undertook the following activities:

- spoke with the Clinical Nurse Lead
- undertook a tour of the ward
- interviewed 11 patients
- interviewed seven carers
- interviewed 13 staff, including staff nurses and senior staff
- reviewed 11 care records looking at daily clinical entries, incidents, risk assessments and risk management plans
- observed patient and staff interactions on the ward, and
- checked the emergency bag.

We also reviewed a range of information including:

- policies and procedures
- minutes of meetings
- patient documentation including daily clinical notes, risk assessments and risk management plans, and physical healthcare documentation, and
- data held by the hospital management team.

Of 11 patients interviewed on inspection, seven patients (64%) raised concerns about their mental health care and treatment. Three patients (28%) raised concerns regarding their physical care and treatment. Patients told us that staff had not always treated patients with compassion and kindness. However, three patients (28%), were happy with aspects of their care and treatment.

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 to improve:

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

- The provider MUST ensure that staff treat patients with compassion and kindness. (Regulation 10) (1)(2))
- The provider MUST ensure that staff undertake physical health observations (NEWS) on a weekly basis in line with ward requirements. (Regulation 12(1)(2)(a)(b))

Summary of this inspection

- The provider MUST ensure that staff undertake physical health observations for all patients following the administration of rapid tranquillisation, line with the provider's policy, and guidance. (Regulation 12 (1)(2)(a)(b)(g))
- The provider MUST ensure that staff respond to patient's physical healthcare needs in a timely way. (Regulation 12 (1)(2)(a)(b))
- The provider MUST ensure that appropriate actions are taken in response to identified patient risk and self-harm. (Reg 12(2)(a)(b))
- The provider MUST ensure that all incidents are recorded in the patient's clinical records. (Reg 12(2)(a)(b)) Reg 17(1)(2)(c))
- The provider MUST ensure that patient risk management plans and daily clinical records are kept up to date to reflect patient risks. (Regulation 12) (1)(2)(a)(b)) Reg 17 (1)(2)(c))
- The provider MUST ensure that the risk register is updated to reflect current concerns relating to patient risk. The provider MUST ensure that staff have access to the risk register and is aware of its contents. (Reg 17(1)(2)(a))
- The provider MUST ensure that actions are taken to address the ongoing high number of medication errors. (Regulation 12(1) (2)(b)(g))
- The provider must ensure there is governance and oversight to highlight issues of non-compliance in all aspects of care and treatment. (Regulation 17(1)(a)(b)(c))
- The provider MUST ensure that all staff are up to date with all aspects of their mandatory training, including Mental Capacity Act and Deprivation of Liberty (DoLs) and ligature awareness. (Regulation 12(1) (2)(a)(b)(c))
- The provider MUST ensure that staff have the necessary skills and competencies to meet the need of the patients on the ward. (Regulation (18)(1)(2)(a))
- The provider MUST ensure that remedial action is taken to address the blind spots on the ward. (Regulation 15(1)(c))
- The provider MUST ensure that patients are fully involved in their care planning process. (Regulation 9(1)(3)(a)).
- The provider MUST ensure that the system for complaint management is reviewed to ensure that patient complaints are managed robustly. (Regulation 16(1)(2))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Not inspected	Inadequate	Not inspected	Inadequate	Inadequate
Overall	Inadequate	N/A	Inadequate	N/A	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Caring	Inadequate
Well-led	Inadequate

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inadequate

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

- We found three blind spots in the ward. One was situated in the patient lounge and the other two were cited in the main ward corridor. Managers had not identified, recorded or mitigated these blind spots on the environmental risk assessment. The ligature risk assessment was completed in November 2020.
- The layout of the ward complied with guidance on the elimination of mixed sex accommodation. There was a designated female only lounge and separate corridors for male and female patients
- Staff had not undertaken daily checks of emergency equipment as required. The emergency bag kept in the clinic had an out of date single patient manual resuscitator**.** This item was equipment used for emergency life support. This was raised with the nurse in charge, and we have been assured that this has now been replaced.
- The provider reported that as 05 March 2021, 86% of staff had completed their mandatory training. However, the minutes of the clinical governance meeting for March 2021, identified that two mandatory training completion rates were below 75%. The current training rate for the Mental Capacity Act and Deprivation of Liberty (DoLs) training was 70%, and ligature awareness was 52%.
- We found gaps in the skills and competencies of staff. Staff and patients told us that staff did not have some of the essential skills required to care for the current client group. One patient told us that staff were not able to fully address patient physical health care issues. Another patient and two staff members told us that staff did not have the skills and expertise in managing patients with an eating disorder. One patient told us that staff were not skilled in managing patients who were experiencing flashbacks. We raised these issues with the provider at the time of our inspection. The provider has undertaken investigations into each of these allegations.
- Staff had not always completed routine monitoring of patient's physical healthcare. We reviewed the national early warning signs (NEWS) recordings from the beginning of January 2020 to the end of March 2021. We found that there were gaps in the recording of patient's physical health observations throughout this period. The lowest number of gaps was for week commencing 15 March 2021, where there were five gaps out of 22 patients (23%). The highest number of gaps was for week commencing 22 March 2021, where there were 16 gaps out of 23 patients (70%). This included two patients who were on high doses of anti-psychotic medication.
- Three patients told us that staff had not responded appropriately to their physical health needs. One patient told us that staff had not responded to reports of chest pain, which had continued for over five hours. The patient told us they rang 111, who then called the paramedics. The patient stated that they were subsequently admitted to the local acute hospital. Another two patients told us that staff had not responded when a patient was having a seizure in a communal area of the ward and had vomited. Both patients reported that staff had prevented patients from placing the patient into the recovery position. A third patient told us that they had reported a urinary infection and had been prescribed

antibiotics. The patient told us that they had informed staff that the antibiotics were not working. However, staff did not respond. The patient was subsequently transferred to a local acute hospital to treat the infection. We raised these concerns with the provider at the time of our investigation. The provider subsequently investigated, corroborated and had taken appropriate action in response to each of these incidents.

- We reviewed risk assessment and risk management plans, daily notes and incidents for 11 patients. We saw that risk assessments had not been reviewed following an incident in six of the 11 records reviewed (55%). In all six cases, the risk assessment should have been updated following the incident.
- Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff tried to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We reviewed one incident of restraint and noted this had not been documented in the patient's daily clinical entry. The incident had not been documented within the patient's daily clinical entry. Staff had not provided details on the incident form about which position staff had been in when involved in restraint. Therefore, there was no evidence of learning in response to the restraint.
- Staff had not taken remedial actions to reduce the risk of further self-harm events taking place. In the 12-month period prior to our inspection, the provider has reported 18 self-harm incidents. We found that patient observations had not always been reviewed after an incident of self-harm. Staff had not been trained to conduct patient searches, and the provider had not reviewed the list of contraband items.
- Staff had easy access to clinical information, and it was easy for them to access clinical records – whether paper-based or electronic. However, the daily clinical records entries did not always provide accurate details of patient incidents and daily progress. Records were stored securely.
- The provider had not always used safe systems and processes to safely administer medicines. Staff had reported high numbers of medication errors. Medication errors had been identified in medication audits and minuted in risk management meetings from August 2020. We found that over the four months September 2020 to end January 2021, there had been a total of 187 medication errors. The highest number of errors (62) had been reported in December 2020. and 11 errors in January 2021. Senior managers had been made aware of the errors and these had been discussed and documented in senior management meeting minutes. The minutes reported that managers were to 'introduce a consequence culture' in response to the ongoing errors. Managers recorded in the clinical governance meeting of 29 January 2021, that 'persistent errors would result in disciplinary action'. We saw no evidence of a thematic review of medication errors, and we could not be assured that learning to prevent future occurrence had taken place.
- Staff had not always undertaken physical health observations following administration of medication. We found two incidences where patient's physical health recordings had not been taken or recorded following rapid tranquillisation in line with best practice.
- We found annual physical health reviews had not been completed within the date due. The out of date annual medical reviews had been raised in the senior management meeting minutes of August 2020 and appeared in the meeting minutes of subsequent months. Despite the provider being aware of the overdue reviews, action had not been taken to undertake the outstanding annual physical health reviews.
- We reviewed 11 patient incidents alongside the patient's clinical records, risk assessment, care plans and other documentation. Staff had managed most patient safety incidents they had been made aware of. However, the provider had not always provided full details of the incident within the patient's clinical records. Staff had not recorded the incident number in five of the 11 (45%) patient clinical records viewed. However, managers investigated incidents once they had been made aware of them. Managers had not been made aware of all incidents. Managers ensured that learning from incidents had been cascaded to staff.
- The provider did not have a good track record on safety. The provider had not always managed patient safety incidents well, once reported. We viewed a total of 241 provider incidents from 1 January to 9 April 2021. The incident data showed that there had been a high number of self-harm incidents. These accounted for 47% of all incidents. The data showed that some patients had been able to self-harm whilst on enhanced observation. There was limited evidence that remedial actions had been taken to reduce the risk of further self-harm events taking place. We found that patient

observations had not always been reviewed after an incident of self-harm. Staff had not been trained to conduct patient searches. Staff had not always searched patients and their rooms to identify items which could be used for self-harm following incidents. We could not be assured that patients were kept as safe as possible to prevent self-harm reoccurring.

- Staff did not make complete recordings of enhanced observations which had been put in place to keep patients safe and in many cases, prevent patients from self-harm. We found gaps in the recording of enhanced patient observations. We viewed observation records between the 7 March and 5 April 2021. During this 30-day period, there was a total of 35 hours of gaps in recording. On one day, we found gaps of enhanced observations of five hours. On another day, we found gaps of enhanced observations of three hours. However, we examined the gaps in recordings against the incidents of self-harm and found that where recordings had not been made, self-harm had not taken place.

However,

- The wards were generally clean well equipped, well furnished, well maintained and fit for purpose. Staff followed infection control policy and COVID-19 guidance, including hand washing. Staff and visitors had their temperature recorded on entry to the building. The provider had ensured that staff had access to personal protective equipment (PPE). Management of COVID-19 had been managed in line with public health guidance following an outbreak of the infection amongst staff and patients. For example, a separate entrance and exit for staff away from the main entrance and a designated changing room for staff to change into scrubs.
- Managers had accurately calculated and reviewed the number and grade of nurses, nursing assistants and for each shift. The ward manager could adjust staffing levels according to the needs of the patients. The provider had enough numbers of nursing and support staff to cover shifts. However, in the three-month period 1 January 2021 to end March 2021, the provider used a total of 175 hours of agency. During this period there had been a major outbreak of COVID-19, which had affected several staff. Managers had supported staff who needed time off for ill health and for those who needed to shield due to COVID-19.
- At the time of inspection, no staff were off sick. However, staff turnover as at end of March was 11.43%. The provider had six vacancies for staff nurses and six vacancies for health care assistants. Managers reported four leavers in January 2021.
- Most staff had attended safeguarding training. The overall current figures for staff, across the hospital who had attended safeguarding training as of March 2021 was 92%. A detailed training needs analysis was completed by the provider immediately following inspection. Plans are now in place to address the outstanding training needs for all staff.
- Staff had not recognised and reported all incidents appropriately. Managers investigated incidents and shared lessons learned with the whole team.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Inadequate

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

- Patients told us that staff had not always treated them with compassion and kindness. During our inspection, we spoke to 11 patients. One patient told us that staff had shouted and made the patient feel inadequate. Another patient told us that they hadn't been spoken to very nicely. A third patient told us that some staff "shout at patients". The provider reported that they had received 14 patient complaints in relation to staff attitude and behaviour. One out of seven carers interviewed when asked if staff had been kind, told us that "some of the staff had not been nice".

Long stay or rehabilitation mental health wards for working age adults

Inadequate

- Staff had not always been discreet, respectful, and responsive when caring for patients. One patient told us that they had been accused in front of other patients, of having bullied staff. A third patient told us that a nurse had said "I don't want to sit and eat with these people".
- Patients told us that staff did not always give patients help, emotional support and advice when they needed it. One patient told us that they had felt punished for being unwell. Another patient told us that when they had approached staff when distressed had been told to move out of the day room as "mopping the floor was the priority". The patient added that the staff member had added "you can self-harm anywhere". The patient alleged that they had been told to sleep on the sofa in the day room without a blanket and pillow when distressed. Another patient told us that she had been left wet after being incontinent of urine after being emotionally distressed on two separate occasions. We discussed issues raised by patient with the provider during high level feedback. The provider told us that they were not aware of two of the issues reported. Two incidents had been resolved and three were to be reviewed. The provider arranged for an independent review to take place, into all of the concerns raised by patients immediately following the inspection. Managers have developed an action plan to address the issues patients had raised during inspection.
- We found that staff had not always involved patients in their care planning and risk assessments. One patient told us that they were not aware that they had a care plan for a number of months. Another patient told us that they had not been told the date of their care programme approach meeting. Two out of seven carers interviewed told us that staff had not communicated with them regularly and they had not been updated regarding the patient's care.

However:

- Five out of seven carers interviewed (71%) stated they had no concerns about the care at Cornerstone House. One patient stated they were happy on the ward. Another patient told us they liked it at the hospital.
- Patients could give feedback on the service and their treatment via a two weekly patient forum and suggestion box.
- Staff gave patients an induction booklet on admission to the hospital.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Inadequate

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

- Governance processes were not operating effectively, and performance and risk issues had not been managed well. Leaders did not have all the skills, knowledge and experience to perform their roles. The provider held regular clinical governance meetings, however we found that actions had not always been taken to address identified concerns and risks.
- Medication errors had been identified in medication audits and minuted in risk management meetings from August 2020. We found that over the four months September 2020 to beginning of February 2021, there had been a total of 187 medication errors. Senior managers had been informed of the errors, which were discussed in senior management meetings. The minutes reported that managers were to 'introduce a consequence culture' in response to the ongoing errors. Managers recorded in the clinical governance meeting of 29 January 2021, that 'persistent errors would result in disciplinary action'. We saw no evidence that a thematic review of medication errors had taken place, and we could not be assured that learning to prevent future occurrence had taken place.
- We found the system and process for the management of complaints was not effective. When things went wrong, staff had not always apologised and given patients honest information and suitable support. When patients made

complaints about how staff treated them, the complaint was not formally investigated and only resolved through a conversation with the patient. The managers did not have a way to record if the complaint had been upheld, not upheld or partially upheld. This meant learning from complaints could not take place to minimise the risk of re-occurrence. raising concerns

- Managers did not routinely discuss complaints in the senior management meeting. The provider had not maintained a record of which complaints had or had not been upheld. This meant that learning from complaints had not been identified or shared to prevent re-occurrence. Complaints had been dealt with where possible informally, which involved a staff member discussing how to resolve the issue with the patient. Four patients interviewed (36%) told us they had not received a response to their complaint, which had been made in the previous six-month period. Where a patient had made a complaint about a member of staff, managers had not involved HR in the process. During our inspection we spoke to the HR manager, who confirmed that HR should be made aware of any complaints about a staff member. There were 14 recorded complaints made by patients between 17 July 2020 and 26 March 2021 about staff. We saw no evidence the provider had fully investigated the complaint or provided a formal response to the patient.
- Managers had not monitored compliance with physical health care checks. We reviewed the clinical governance meeting minutes between November 2020 and March 2021. The minutes of the clinical governance meetings did not evidence that physical healthcare had been discussed during this time. We found evidence of gaps in annual physical health assessments and in regular recording of NEWS. Managers had not taken timely steps to address this shortfall.
- Minutes of clinical governance meetings did not show evidence of audits of clinical documentation such as risk assessments.
- There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents, was shared and discussed. However, not all learning had been shared. We were unable to find evidence of changes in practice following several incidents.
- Managers told us that the Registered Manager maintained the risk register, and that this was being reviewed. However, staff at ward level were not aware of the risk register or its contents.

However:

- A new management company had taken over ownership of Cornerstone House in March 2020. Consequently, a new senior leadership team had been brought in at board level. In addition, there were a number of changes to the senior management team at Cornerstone House, who introduced certain changes to systems, processes and ways of working within the hospital.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. Leaders were visible in the service and approachable for patients and staff.
- Staff had access to the equipment and information technology needed to do their work. Information governance systems included confidentiality of patient records. The service used systems to collect data from the ward that were not over-burdensome for front-line staff.
- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on.
- Patients had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients had been involved in decision-making about changes to the service. This had included patient involvement in corporate induction. However, due to COVID-19, the co-production meetings had not been taking place.
- Patients and staff could meet with members of the provider's senior leadership team to give feedback. Directorate leaders engaged with external stakeholders – such as commissioners and the safeguarding team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints • The provider had not ensured that the system for complaint management had been reviewed to ensure that patient complaints are managed robustly. (Regulation 16(1)(2))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider had not ensured that remedial action had been taken to address the blind spots on the ward. (Regulation 15(1)(c))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had ensured staff that physical health observations (NEWS) had been undertaken a weekly basis in line with ward requirements. (Regulation 12(1)(2)(a)(b)) • The provider had not ensured that physical health observations for all patients had been recorded following the administration of rapid tranquillisation, in line with the provider's policy, and guidance. (Regulation 12 (1)(2)(a)(b)(g)) • The provider had not ensured that staff had responded to patient's physical healthcare needs in a timely way. (Regulation 12 (1)(2)(a)(b))

This section is primarily information for the provider

Requirement notices

- The provider had not ensured that appropriate actions were taken in response to identified patient risk and self-harm. (Reg 12(2)(a)(b))
- The provider had not ensured that all incidents were recorded in the patient's clinical records. (Reg 12(2)(a)(b)) Reg 17(1)(2)(c))
- The provider had not ensured that patient risk management plans and daily clinical records were kept up to date to reflect patient risks. (Regulation 12) (1)(2)(a)(b)) Reg 17 (1)(2)(c))
- The provider had not ensured that actions had been undertaken to address the ongoing high number of medication errors. (Regulation 12(1) (2)(b)(g))
- The provider had not ensured that all staff were up to date with all aspects of their mandatory training, including Mental Capacity Act and Deprivation of Liberty (DoLs) and ligature awareness. (Regulation 12(1) (2)(a)(b)(c))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider did not ensure that staff treat patients with compassion and kindness. (Regulation 10) (1)(2))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider had not ensured that patients were fully involved in their care planning process. (Regulation 9(1)(3)(a)).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not ensured that all incidents were recorded in the patient's clinical records. (Reg 12(2)(a)(b)) Reg 17(1)(2)(c)) • The provider had not ensured that the risk register had been updated to reflect current concerns relating to patient risk. The provider MUST ensure that staff have access to the risk register and is aware of its contents. (Reg 17(1)(2)(a)) • The provider had not ensured there was governance and oversight to highlight issues of non-compliance in all aspects of care and treatment. (Regulation 17(1)(a)(b)(c))
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured that staff have the necessary skills and competencies to meet the need of the patients on the ward. (Regulation (18)(1)(2)(a))