Glenhurst Lodge

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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

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

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

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

Overall summary

We found the service provider to be in breach of regulation 9 person-centred care, regulation 12 safe care and treatment and regulation 14 meeting nutritional and hydration needs. We took enforcement action and issued a warning notice under each of the regulations on 21 November 2016. The warning notice served notified the service provider that the Care Quality Commission had judged the quality of care being provided as requiring significant improvement. We told the service provider that they must comply with the requirements of the regulations by 10 February 2017.

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

- Care plans were not rehabilitation or recovery focused. Care plans were not always based on individual need or preferences and did not clearly reflect patients' goals and the steps needed to achieve these. Patients who were self-administering medicines did not have robust care plans in place to support them and information in the care plans conflicted with their clinical assessments. Staff did not regularly complete activity interest checklists with patients to ensure that care or treatment was designed to meet their individual needs and preferences. Where patients had shown an interest in certain activities they were not always supported to achieve these goals.

Summary of findings

- Staff did not always update care plans or record in them how staff intended to support patients in their rehabilitation or recovery. They did not specifically detail what level of support individual patients needed and how best to motivate and encourage them.
- Physical healthcare needs were not always incorporated into patient care plans or were limited in detail.
- Physical healthcare checks were not always recorded clearly and consistently so that staff could quickly identify any changes or concerns and take the required action. The service used a standardised system called Modified Early Warning System. However, recordings were incorrectly documented and staff did not alwlays respond to concerns and take the required action.
- There was limited active partnership working with external healthcare professionals. Information was not always shared effectively. Communication between the hospital and general practitioner (GP) was not clearly documented. Reasons for clinical decisions or outcomes that the GP had made were not clearly recorded in patient notes.
- Staff did not assess patients' nutritional or hydration needs. Patients' nutritional intake was not consistently recorded or monitored to ensure they received the support they needed to sustain good health and an appropriate diet. It was not possible to tell if patients were having a well-balanced diet, or how staff were supporting or encouraging them do this. Care plans did not contain any detail about a patient's nutritional intake or the level of support needed. Staff did not carry out any screening assessments with patients as per the provider's policy. Staff did not carry out assessments with patients to establish their skill level in budgeting and cooking. Appropriate support was not available to patients as a result of lack of assessments.
- There were limited activities outside the hospital for patients to participate in. The service had no links with any of the local colleges or adult education centres and had not established links with the local community to help facilitate voluntary work and reintegrate any patient, who wished to, back into the community.

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

- A multidisciplinary team meeting took place each week. Staff from mental health disciplines including, doctors, nurses, psychologist and occupational therapist attended.
- The Mental Health Act was applied correctly. Patients had access to an independent mental health advocate.
- Patients had their capacity to consent to treatment assessed.
- All patients had a health action plan folder.

Summary of findings

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Glenhurst Lodge

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Our inspection team

The team comprised one inspector from the Care Quality Commission (CQC), a Mental Health Act reviewer and a nurse with expertise in long stay rehabilitation.

Why we carried out this inspection

We undertook this unannounced follow up inspection to find out whether the provider had made improvements to their long stay/rehabilitation mental health wards for working age adults since our last announced comprehensive inspection of the service on 2 and 3 September 2015.

When we last inspected the service in September 2015, we rated long stay/rehabilitation mental health wards for working age adults as **good**.

Following the inspection in September 2015, we rated the service as good for safe, caring, responsive and well-led and as requires improvement for effective.

Following that inspection, we told the provider that it must take the following actions to improve long stay/ rehabilitation mental health wards for working age adults:

- The provider must ensure patients have care plans that reflect their needs and goals and how these are to be achieved. This should include matters relating to food so that staff are assured that patients have the necessary support to make choices about a balanced diet.
- The provider must ensure that staff have training about the Mental Health Act.

We also told the provider that it should take the following actions to improve long stay/rehabilitation mental health wards for working age adults:

- The provider should ensure staff have the necessary skills to work with patients using a rehabilitation/ recovery model.
- The provider should ensure that physical healthcare checkis are recorded clearly and consistently so that any changes are concerns can be quickly identified.
- The provider should ensure that food is stored appropriately and not kept beyond the use by dates.

We issued the provider with two requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 Safe care and treatment.
- Regulation 18 Staffing.

Following the inspection on 21 and 29 September 2016, we issued the service provider with a warning notice due to significant concerns regarding patients' care and treatment which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 Person-centred care.
- Regulation 12 Safe care and treatment.
- Regulation 14 Meeting nutritional and hydration needs.

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following question:

- Is it effective?

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

During the inspection visit, the inspection team:

Summary of this inspection

- spoke with the registered manager
- spoke with seven staff, including nurses, support workers, occupational therapists and doctor
- spoke with six patients
- spoke with four relatives/carers
- looked at 11 patients care records, including care plans, assessments, physical health monitoring, nutrition and hydration.
- attended and observed a daily planning meeting on Davenport ward
- carried out a specific review of the Mental Health Act on Davenport ward

looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Glenhurst Lodge

Glenhurst Lodge is registered to provide the regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; accommodation for persons who require nursing or personal care; treatment of disease, disorder or injury; and diagnostic and screening procedures.

Glenhurst Lodge has two locked rehabilitation wards for working age adults. Davenport ward has 11 beds for males and Sandown ward has 11 beds for females. During the inspection, the service was providing care or treatment to 11 men and 10 women.

We have inspected Glenhurst Lodge six times since registration with the Care Quality Commission (CQC) in 2011. We last inspected this service as part of a comprehensive inspection in September 2015. During that inspection, we found that the provider had breached two of the regulations. We asked the service to take steps to address the breaches of regulation and the service responded with an action plan to do this. Following the inspection on 21 and 29 September 2016, we issued the provider with a warning notice due to significant concerns regarding patients' care and treatment. The service is now not meeting three of the current regulations.

What people who use the service say

We spoke with six patients during the inspection. Most told us that staff were caring and were available to speak with them when needed. Patients on both wards told us that there were often delays in accessing their section 17 leave. Personal shopping and food shopping trips were delayed at times due to staff shortages. Patients told us that the door to the garden area remained locked. This meant there were often delays in accessing the garden area as patients had to wait to be escorted, even if an informal patient. Patients told us they liked the food as they got to choose what they wanted to eat and cook but that they would like more help in choosing healthier options.

We spoke with four relatives/carers during the inspection and received mixed reviews on the service. Three relatives were generally happy but felt more support needed to be provided to rehabilitate their relative back into the community. Three relatives felt that their relatives were not supported to eat a healthy balanced diet and relatives had put weight on as a result of this. Most told us they felt their relative was safe whilst at the service. One relative was extremely happy with the service and had noticed improvements in their relative's mental health since their transfer to the hospital.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services effective?

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

- Care plans were not rehabilitation or recovery focused. Care plans were not always based on individual need or preferences and did not clearly reflect goals and how these would be achieved.
- Staff did not always update care plans or record in them how staff intended to support patients in their rehabilitation or recovery.
- Physical healthcare needs were not always incorporated into patients' care plans or were limited in detail.
- Physical healthcare checks were not always recorded clearly and consistently so that staff could quickly identify any changes or concerns and take the required action.
- There was limited active partnership working with external healthcare professionals. Information was not always shared effectively.
- Staff did not assess patients' nutritional or hydration needs. Patients' nutritional intake was not consistently recorded or monitored to ensure they received the support they needed to sustain good health and an appropriate diet.
- Staff did not regularly complete activity interest checklists with patients to ensure that care or treatment was designed to meet their individual needs and preferences.
- There were limited activities outside the hospital for patients to participate in.

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

- A multidisciplinary team meeting took place each week. Staff from mental health disciplines including, doctors, nurses, psychologist and occupational therapist attended.
- The Mental Health Act was applied correctly. Patients had access to an independent mental health advocate.
- Patients had their capacity to consent to treatment assessed.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We carried out a specific review of the Mental Health Act on Davenport ward. We reviewed six detained patients' records and found that the paperwork was completed correctly.

Staff received mandatory training in the Mental Health Act and Mental Capacity Act. At the time of our visit, 83% of staff had completed this.

Information was displayed on the ward noticeboards regarding the independent mental health advocate (IMHA) and how to contact them. However, staff were not monitoring how many patients were referred to the IMHA or if patients were referred automatically because they lacked the capacity to make a self-referral.

Detained patients were mostly informed of their rights in accordance with section 132 of the Mental Health Act. Staff recorded this on the providers section 132 form. However, staff did not always record this in the patients' progress notes as well.

Patient files reviewed showed that all had an assessment of their capacity to consent to treatment.

Patients' medicine charts had photographic evidence of patients attached, copies of consultation with statutory consultees together with T2 or T3 treatment authorisation certificates.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the Mental Capacity Act and Depriviation of Liberty Safeguards (DoLS). At the time of the inspection 80% staff had completed the training.

There were no patients in the hospital at the time of our inspection who were subject to a DoLS authorisation or awaiting a DoLS assessment following an application by the hospital.

Long stay/rehabilitation mental health wards for working age adults

Effective

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Assessment of needs and planning of care

During our last inspection in September 2015, we found that care plans did not reflect the patients' individual needs and goals or how these were to be achieved.

During this inspection, we reviewed 11 care records of patients across both wards, looking at areas such as initial assessments, care planning, physical healthcare monitoring, nutrition and hydration.

The service had implemented a multidisciplinary care plan that was based on "My Shared Pathway" which was a patient focused recovery model of care. A care pathway is a structured approach to care delivery that clearly describes the journey a person is likely to take when moving through the care system. This ensures that individuals receive the most appropriate care and treatment, with clearly agreed timescales and in the least restrictive environment. However, during the inspection we were concerned that patients were not receiving care and treatment that was based on an assessment of their individual needs and preferences. We found limited evidence of rehabilitation or recovery care plans being used. For example, care plans advised staff to "support patients" to follow their daily activity timetable. They did not specifically detail what level of support that individual patient needed and how best to motivate and encourage them. There was very little evidence of patient involvement in the care plans that staff had written. Outcome measures were mostly generic across all patients' care plans and target dates were not set.

Care plans did not reflect what steps patients needed to take to achieve their goals. For example, what a patient needed to do to move from escorted section 17 leave to unescorted section 17 leave. There was no staged plan to support patients. There was no process in place to measure patients' progress and support them to acquire new skills as part of their recovery and rehabilitation.

Staff did not regularly complete activity interest checklists with patients to ensure that care or treatment was designed to meet their individual needs and preferences. Out of the 11 care records reviewed, we found only three activity interest checklists had been completed by staff with patients. No review of these had taken place to ensure that they were still relevant to the patient. For example, where patients had shown an interest in college courses or voluntary work they were not supported to achieve these goals.

There was an activity timetable displayed on the ward. There were 13 activities available including brunch club, river walk, shopping, karaoke, planning meeting and current affairs. The service carried out a patient activity satisfaction survey in September 2016. Results showed that patients felt involved in the planning of activities and staff supported them to attend. However, patients also identified that activities could be improved.

The service had no links with any of the local colleges or adult education centres and had not established links with the local community to help facilitate voluntary work and reintegrate any patient who wished to back into the community.

During the inspection, three patients were self-administering medications as part of their rehabilitation. The provider's policy for self-administration of medication - the Bramley Health 'self-administration of medication in hospital & nursing homes policy', was implemented on 1 October 2015. This policy stated that all patients identified as being suitable for the self-administration programme needed to have a clinical assessment carried out by the nurse, with the patient. We were concerned that none of the three patients who self-administered medicines had any clinical assessments or care plans in place as per the provider's policy. We specifically requested evidence from staff to demonstrate this during the inspection visits, who were unable to provide us with any active documents. There was no information about what date the patients started self-administering medications, what support they needed and the incremental steps needed to help them progress and what would happen should a patient not be able to adhere to the programme. There was no evidence to show

that patients understood their medications and consented to the programme. Staff were not actively monitoring patients success using the monitoring form and the progress of patients was not reviewed by the multidisciplinary team fortnightly as per the policy. There was no evidence to show that any of the three patients had been involved in any of the decisions made about their care or treatment. Subsequently, after the inspection visits, the provider submitted documents to the Care Quality Commission, including care plans, clinical assessments and multidisciplinary review meeting minutes. However, information contained in these documents did not correspond and was conflicting.

During our last inspection, we found that physical healthcare checks were not always recorded clearly or consistently so that changes or concerns could be quickly identified and responded to. The records we looked at during this inspection showed that staff conducted an initial physical health check of patients on admission. Staff checked the physical health of patient's by undertaking observations such as blood pressure and weight. However, staff did not carry these out weekly for all patients as per the provider's physical health policy.

The service used a standardised system called Modified Early Warning System (MEWS) to monitor and record the physical health of patients. This system worked by staff allocating a score to a series of physical health measures such as blood pressure and oxygen saturation levels. When a patient's score reached a given level this triggered what action was required from staff.

As part of the 11 care records reviewed during this inspection, we found that MEWS were inconsistently completed by staff and contained errors. For example, recordings were incorrectly documented in the score box. The adding up of scores was incorrect. There was no evidence of high scores being followed up. The purpose of the score is to help clinical staff decide whether to call a doctor or emergency service in the event that a patient's health suddenly deteriorated. This meant that staff were not taking the required action to ensure patients' received safe care or treatment. Any abnormal results recorded on MEWS were not then recorded in the patients' daily nursing notes.

The service used the Glasgow Antipsychotic Side-effect Scale (GASS). This is a self-reporting questionnaire used to help identify the side effects of antipsychotic medication. It consists of 22 questions with points assigned based on the answers given by the patient. However, not all patients on antipsychotic medication had been supported by staff to complete the self-questionnaire. Out of the 11 care records reviewed we found only one had a completed GASS assessment, which was not dated.One patient hadreported issues with side effects from medication such as making them feel tired, weak and distressed. The outcome of the GASS assessment was not documented in the patient's daily nursing notes and there was no evidence to show the concerns had been shared or raised with the patient's clinical team or staff had followed this back up with the patient.

Physical healthcare needs were not always incorporated into patients' care plans or were limited in detail. For example, there was no clear guidance about a patient's respiratory disease in their care plan to show how severe it was, what oxygen levels were considered to be of a normal and safe range and what action should be taken if they fell outside of the parameters.

The care records were paper based and stored securely in the staff office. Minutes from the multidisciplinary team ward rounds were updated live via a laptop during the meeting and projected for all to see. These were then printed off and put in the patients file with the other paper records.

Best practice in treatment and care

Patients were referred to a psychologist if a need was identified and were seen on an individual basis.

Each patient had a health action plan (HAP) folder. A HAP is a personal plan about what the patient needs to do to stay healthy, including a record of past and future medical appointments. Staff referred patients to external healthcare services for treatment when needed such as opticians and dentistry. This was then recorded in the patients HAP. Out of the 11 care records reviewed, we found that most of the HAP were kept up to date. However, staff did not always record in the patients' HAP the last date visited to a healthcare practitioner, for example when annual health checks were carried out by the general practitioner (GP). Staff recorded some patients' health care appointments on the providers health appointment record forms. However,

the recording of this was inconsistent and did not always follow through to the patients HAP or progress notes. All patients were registered with a GP and visited them when necessary.

During the last inspection we found that patients' food intake was not monitored to ensure they were eating a balanced diet. In response to this, the provider put an action plan in place and told us food diaries would be completed and closely monitored and that dietary needs training would be provided to staff and patients.

At the time of the current inspection, we found continuing concerns in this area. We found that patients' nutritional information was not always monitored or recorded by staff. It was not possible to tell if patients were having a well-balanced diet, or how staff were supporting or encouraging them to do this.

The hospital did not operate a main kitchen. There was a kitchen on each ward which had two cookers. Each patient had a weekly budget of £30 and were encouraged to budget, shop and cook for themselves. Each patient had their own food cupboard and there were shared items such as fruit, bread and milk.

We looked at 11 patients' weekly food diaries over an eight-week period, from the 25 July 2016 to the 12 September 2016 inclusive. We were concerned that staff had not assessed patients' nutritional or hydration needs to support ongoing good health and ensure that support and encouragement was given when needed. Nutritional intake was not consistently recorded or monitored to prevent unnecessary weight loss or weight gain. Reviews were not completed on any of the 11 food diary records to ensure that changes in patients' needs could be responded to without delay.

The food diaries showed very little evidence that patients were receiving the support they needed from staff to sustain good health and an appropriate diet. The food recorded predominantly consisted of sugary drinks, sandwiches, processed food and ready meals. There was no evidence to show that food diaries were monitored or reviewed. Potential concerns were not identified and opportunities to take action were missed by staff. For example, we found multiple entries on the patients' food diaries where staff had documented that the patient either had refused or declined meals. This was not recorded in the patients' daily nursing notes and we found no evidence to show that this was shared with the multidisciplinary team.

We reviewed the provider's food and nutrition policy date implemented 1 October 2015. The policy states that all patients will be screened for malnutrition using the Malnutrition Universal Screening Tool (MUST). Once completed patients would then be categorised as low risk, medium risk or high risk. Clear guidelines were documented as to what action staff would need to take. For example, making referrals to a dietitian or speech and language therapist and the frequency of monitoring and reviewing nutritional care plans. However, we found no record of MUST being used in any of the 11 records we reviewed. We spoke with staff who told us that they were not aware of the screening tool and were not using it. Staff told us that any referrals for a speech and language therapist or dietician would be made via the GP if the need was identified.

We reviewed 11 care plans. Limited information about nutrition was inconsistently documented in the section 'Staying healthy' or 'My life skills'. Care plans did not contain any detail about a patient's nutritional intake or the level of support needed. Because staff did not carry out screening assessments, patients who would otherwise be identified 'at risk' were not offered appropriate support.

Care plans were not individual and contained limited or no information as to what support patients' needed with planning, budgeting, or producing well-balanced meals. For example, care plans stated for staff to support the patient with planning healthy weekly meal plans and support with budgeting. However, we found that weekly planning and budgeting sheets were not regularly completed by staff and many had gaps in them. Patients told us that staff were meant to discuss meal choices with them every Wednesday but this rarely happened.

We found no evidence that patients had been assessed by staff to establish their level of skill in budgeting and cooking. Appropriate support from staff was not provided as a result of lack of assessments.

Staff facilitated a monthly clinic to discuss health promotion with patients, specifically related to healthy eating. Staff told us that they would try and motivate patients to attend when possible. However, not all staff

were adequately trained to advise or support patients in choosing healthy meal options. Information given to us by the service showed that staff at the hospital had been provided with in house training on dietary needs and food checks. However, at the time of our inspection, only 33% of staff had completed this course. Staff did not always document which patients attended the sessions.

Health of the nation outcome scales(HoNOS) were completed in patient records.

Staff actively participated in clinical audits including infection control and environmental audits.

Skilled staff to deliver care

Both wards had input from a range of professionals, including nurses, support workers, occupational therapist, forensic psychologist and psychiatrist. The occupational therapist was a locum, having only been in post a few weeks prior to the inspection. Activities for patients were still in the process of being embedded.

All staff received an induction, which included a corporate and unit induction. New staff were assigned a mentor and completed their mandatory training. This was a mix of e-learning and face to face training.

Staff had regular supervision. The staff we spoke with were happy with the quality of supervision they received and felt that they could approach their peers or members of the multidisciplinary staff if they needed support or advice.

Staff did not always receive the necessary specialist training. We reviewed the training matrix and were concerned that only four out of a possible 27 nurses and support workers had completed training in diabetes. The hospital manager had also completed the training. During the inspection, we observed staff carrying out blood sugar monitoring. The training matrix showed that this staff member had not completed training in diabetes. There was no evidence to show that staff were carrying out quality control checks on the blood glucose monitoring device, aware of the need to do so or trained to do so. When we spoke to staff they confirmed this.

Multidisciplinary and inter-agency team work

Multidisciplinary team (MDT) meetings took place weekly at the hospital. Each patient was seen and/or reviewed by the MDT every other week. We looked at the MDT meeting minutes for the 11 care records reviewed and found that issues such as life skills, physical health and capacity and treatment were discussed. However, information was not always consistently recorded. For example, when a concern or change had been highlighted with a patient's physical health this was not recorded as being discussed in the next MDT minutes. It was therefore not clear if information across the MDT was being communicated and shared effectively.

We were concerned that there was limited active partnership working with external healthcare professionals. The processes in place to support this were not effective. For example, there was a communication risk when patients saw the general practitioner (GP). There was no process in place to ensure that information was effectively and safely conveyed between the professionals sharing the patient's care. Staff escorting the patient to medical appointments were expected to verbally communicate concerns to the GP and any action taken back to the service. However, we found that this was not happening. Reasons for clinical decisions or outcomes that the GP had made were not clearly recorded in the patients' notes.

Adherence to the Mental Health Act and the Code of Practice

Staff received mandatory training in the Mental Health Act and Mental Capacity Act. At the time of our visit, 83% of staff had completed this.

Information was displayed on the ward noticeboards regarding the independent mental health advocate (IMHA) and how to contact them. However, staff were not monitoring how many patients were referred to the IMHA or if patients were referred automatically because they lacked capacity.

Detained patients were mostly informed of their rights in accordance with section 132 of the Mental Health Act. Staff recorded this on the providers section 132 form. However, staff did not always record this in the patients' progress notes as well.

Patient files reviewed showed that all had an assessment of their capacity to consent to treatment.

Patient medicine charts had photographic evidence of patients attached, copies of consultation with statutory consultees together with T2 or T3 treatment authorisation certificates.

Long stay/rehabilitation mental health wards for working age adults

Staff were able to access advice and guidance on issues relating to the MHA from the hospital mental health act administrator.

We carried out a specific review of the Mental Health Act on Davenport ward. We reviewed six detained patients' records and found that the paperwork was completed correctly.

Good practice in applying the Mental Capacity Act

Staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). At the time of the inspection 80% staff had completed the training.

There were no patients in the hospital at the time of our inspection who were subject to a DoLS authorisation or awaiting a DoLS assessment following an application by the hospital.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure patient care plans are rehabilitation or recovery focused. Care plans must reflect individual needs and goals and how these are to be achieved.
- The provider must ensure care plans are kept up to date.
- The provider must ensure care plans include all physical health care needs and nutritional and hydration needs and what support is needed.
- The provider must ensure physical healthcare checks are recorded clearly and consistently.
- The provider must ensure effective processes are put in place to support partnership working and communication with other healthcare professionals.
- The provider must ensure patients have their nutritional and hydration needs assessed and reviewed.
- The provider must ensure patients have assessments to establish their skill level in budgeting and cooking to ensure appropriate support can be given.
- The provider must ensure all patients have an activity interest checklist completed and these should be regularly reviewed to ensure they meet the patients preferences and needs.
- The provider must increase the level of activity outside of the hospital.

Action the provider SHOULD take to improve

- The provider should record and monitor referrals to the IMHA service.
- The provider should ensure that there are clear protocols in place for using clinical assessments such as GASS.
- The provider should ensure that patients health action plan folders are kept up to date.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans were not rehabilitation or recovery focused. Care plans were not always based on individual need or preferences and did not clearly reflect patients goals and the steps needed to achieve these. Staff did not always update care plans or record in them how staff intended to support patients in their rehabilitation or recovery. Staff did not regularly complete activity interest checklists with patients. There were limited activities outside the hospital for patients to participate in. This was in breach of regulation 9(1)(3)(a)(b)(c)(d)(e)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Physical healthcare checks were not always recorded clearly and consistently so that staff could quickly identify any changes or concerns and take the required action. Physical healthcare needs were not always incorporated into patients' care plans or were limited in detail. There was limited active partnership working with external healthcare professionals. Communication between the hospital and GP was not clearly documented. This was in breach of regulation 12(1)(2)(a)(b)(c)(i)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Staff did not assess patients' nutritional or hydration needs. Patients' nutritional intake was not consistently recorded or monitored to ensure they were eating a balanced diet.** **This was in breach of regulation 14(1)(2)(4)(a)(b)(d)**