Jigsaw Independent Hospital

Quality Report

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Date of inspection visit: 21, 22 and 23 March 2016
Date of publication: 08/08/2016

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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.

Summary of findings

Overall summary

We rated Jigsaw Independent Hospital as **requires improvement** because:

- The hospital was not managing medicines safely. Patients were not always getting the medicines that were prescribed. The correct forms of authorisation or consent for detained patients did not always include all the medicines that were prescribed. There were no monitoring guidelines or policies for high dose antipsychotic treatment or for rapid tranquilisation.
- Staff were not aware of the environmental risks on the wards and the actions needed to lessen them.
- There were blanket restrictions in place, which meant that patients could not make hot drinks and snacks for themselves regardless of whether they had been assessed as safe to do so.
- Training rates for five of the 16 mandatory training courses, including basic and immediate life support, were below the 75% target.
- The information contained in the patients' risk assessments was basic and did not always contain interventions.
- Policies relating to the Mental Health Act had not been updated to reflect the current code of practice.
- The appraisal rate for staff was low (39%) and only 60% of support workers and 71% of qualified staff had received supervision.
- Patients had limited access to psychological support to aid their recovery. Patients did not know what they had to do to be discharged and care plans were not recovery focused.
- Patients who were detained under the Mental Health Act were being prescribed medicines that were not included in the appropriate forms of consent.There were no admission criteria for the hospital so it was difficult to measure if the admission was appropriate
- The governance system was not effective at identifying where care was falling below standards.

However,

- Risk assessments were completed on admission and reviewed regularly.
- Staffing levels and skill mix were planned, and shortages were actioned promptly.
- Patients had access to an independent mental health advocate.
- Staff were caring and treated the patients with kindness and dignity.
- Staff told us they were supported by the management team.
- Complaints were managed well.
- Patients detained under the Mental Health Act had their rights explained to them.
- The service had good links with local commissioners.

Summary of findings

Contents

Requires improvement

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Jigsaw Independent Hospital

Jigsaw Independent Hospital provides care and treatment for up to 36 patients. At the time of the inspection there were 24 patients at the hospital, with 23 being detained under the Mental Health Act and one patient who was informal. Oriel ward was closed for refurbishment.

The provider was registered to provide the following regulated activities :

• Diagnostic and screening procedures

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

• Treatment of disease, disorder or injury

The wards we visited were:

Montrose ward – female rehabilitation ward with seven beds

Linden ward – male challenging behaviour and rehabilitation with 10 beds

Cavendish ward – female challenging behaviour and rehabilitation with 10 beds

The service had previously been inspected in September 2013, when they were compliant with the regulations reviewed.

The service had a registered manager and a controlled drugs accountable officer.

Our inspection team

Team leader: Sharon Watson, CQC Inspector

The team that inspected the service comprised three CQC inspectors and a variety of specialists: a chartered psychologist, a clinical pharmacist and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at a focus group.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service

Summary of this inspection

- conducted a focus group with patients and offered the opportunity for one to one feedback on 17 March, prior to the inspection.
- spoke with the registered manager, operations director, operations manager, general manager, and the head of contracting
- spoke with 10 other staff members including doctors, nurses, a student nurse, an occupational therapist, psychiatrist and a psychologist
- received feedback about the service from seven care co-ordinators or commissioners
- spoke with an independent advocate
- attended and observed one nursing hand-over meeting and one hospital planning meeting
- attended a patient community meeting
- collected feedback from comment cards from six family members
- collected feedback from comment cards from 13 patients
- collected feedback from comments cards from three stakeholders
- looked at six care and treatment records of patients; four of them were complex care records which were case tracked
- checked medication management on all three wards
- observed medicines being administered to patients on Linden ward
- examined in detail the legal files of four patients
- spoke with the Mental Health Act administrator
- looked at a range of policies, procedures and other documents relating to the running of the service
- wrote to all commissioners, stakeholders, GPs, care co-ordinators and volunteer sector placements representatives

carried out a Mental Health Act review of Cavendish ward

Information about Jigsaw Independent Hospital

Jigsaw Independent Hospital provides care and treatment for up to 36 patients.

What people who use the service say

We spoke with nine patients individually. One patient told us that they were on a work placement which took place one day a week. Patients on Linden ward told us about the restrictions in place and that they had to use plastic crockery and cutlery due to the risks of one patient.

One patient told us that they had been cycling on the day of our visit. Another patient told us that there were trips organised for patients who could go on leave. They said they felt their care and treatment was good, staff were kind to them and supportive.

Patients said there was a wide range of activities available but there could be more choice for patients who were unable to go on leave. The food was good but the portion served by the hospital was too small; they told us the plates were not big enough for their take away nights.

Patients told us they knew how to complain if they were unhappy. One patient told us they would contact the commissioners and another patient told us about the advocacy service who would support them.

We received comment cards from 13 patients. Patients wrote that they were happy with the service provided by Jigsaw. Patients stated the care and support was 'ok', with the staff being caring and supportive. Patients wrote how it was nice at the hospital and they felt safe. One patient wrote that the hospital had helped them a lot and they liked the staff. Another patient wrote that they were happy living on Montrose ward, they were treated with dignity and respect, and the staff listen to them. Some patients wrote that they had no comments. One patient wrote they felt staff did not listen to them or respect them; they felt they should be at home with their family.

We received comment cards from six relatives of patients. Relatives stated that they were happy with the service provided by Jigsaw. Relatives wrote about how the care

Summary of this inspection

provided was good and the improvements they had seen when they visited their family members. Relatives commented on how helpful the staff at Jigsaw were and how they received good communication and were invited to meetings.

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 safe?

Inadequate

We rated safe as inadequate because:

- Medicines management concerns included medicines being given after they were stopped, one patient not being given their medicine when they were on day leave and another patient not being given their medicine for two days because it was out of stock. There was an out of date medicine being stored incorrectly. On Montrose Ward there was no medicine disposal bin and medicines were being disposed of in a plastic bag. Three patients were prescribed high doses of antipsychotic medication and there were no monitoring guidelines for high dose antipsychotic treatment. There were no monitoring guidelines for rapid tranquillisation.
- There were five instances where medication had been prescribed which was not authorised by an appropriate form of consent or authorisation.A patient on Cavendish ward had a T3 form in place with instructions for a section 61 review of treatment to be made at a specific time which had not taken place.
- The registered manager carried out environmental and ligature risk assessments but these were held centrally by the registered manager.Staff on the wards did not know about the risk assessments or the identified risks, the risk management and how to lessen those risks within the wards.
- There were blanket restrictions in place. On Linden ward the kitchen was locked and patients had to use plastic crockery and cutlery. The kitchen on Cavendish ward was locked which meant patients could not access hot drinks and snacks.
- Training rates for some mandatory training courses were below the 75% target: immediate life support (64%) and basic life support (65%) were low causing the risk of staff with life support skills not being available should a patient require assistance.
- The information contained in the risk assessments was basic and did not always contain interventions.

However:

- Clinic rooms were well organised and staff completed temperature checks of the fridges and rooms.
- Staff carried out medicine reconciliation checks with appropriate action taken when errors were identified.

Summary of this inspection

- Resuscitation equipment was available and checked regularly.
- Staffing levels and skill mix was planned, implemented and reviewed to keep people safe at all times with any shortages being actioned promptly.
- There was a system in place to report incidents and undertake investigations when required.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Hospital policies and procedures had not been updated to reflect the current code of practice of the Mental Health Act.
- Patients had limited access to psychology provision. There was a limited resource and most of the psychological assessments or interventions were undertaken by an assistant psychologist available for two days a week.
- Staff were not always explaining patients' rights to them when they were admitted.
- Hospital manager meetings were not taking place when sections were renewed.
- There was no evidence of collaborative multidisciplinary working towards discharge planning.Patients were involved in their shared pathway document but when we spoke to them and reviewed the care records it was not clear what they needed to do to focus on discharge.
- The care records had limited historical or supporting information for a decision to be made for admission to a rehabilitation service.
- My shared pathway required further embedding and additional information to support the documentation and process.
- Although the hospital provided specialist training, the number of staff who had received this was low.
- Only 39% of staff had received an appraisal. Supervision rates were low for support workers at 60% and qualified staff at 71%.
- The service did not have a clear statement explaining the admission criteria and how it would support patients with their rehabilitation.This meant it was hard to measure whether the hospital was achieving its goals in terms of outcomes for patients.
- Care programme approach meeting minutes were missing from three out of four files reviewed.
- Although each patient had a health passport, these did not contain the full physical health records for the patient. For example, the care being delivered by the GP was not included.

Summary of this inspection

- Patients who were detained under the Mental Health Act were being prescribed and given medicines that were not included in the appropriate forms of authorisation or consent.

However:

- Paperwork for patients who were detained under the mental health act was up to date and correctly stored.
- Patients had access to an independent mental health advocate who attended the hospital to support patients.
- The service had good links with the local commissioners, mental health trusts and local authority safeguarding teams.

Are services caring?

Good

We rated caring as **good** because:

- Feedback from patients was generally positive about the way staff treated them.
- Patients told us they were treated with dignity, respect and kindness.
- We observed good interactions between staff and patients during our visit.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- There were no admission criteria for the hospital so it was difficult to measure if the admission was appropriate for the service provision.
- The pre-admission process was to follow the admission policy and complete a pre-admission assessment from the information provided within the referral.There was limited information in the care files at referral stage nor a rationale for admission of the patient.
- On some of the wards there were limited rooms available for patients to have quiet space or see their visitors. The environment on Cavendish ward did not allow for patients to have time away from the main communal area.
- Patients were not able to access hot drinks and snacks in Cavendish and Linden Wards.

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However:

- Complaints were managed appropriately and in line with the provider's policy.

Summary of this inspection

- Informal complaints were recorded to allow staff to consider any other appropriate action such as escalation to formal complaints or consideration of the vulnerable adults policy.
- Notice boards provided information for patients and their families.
- Patients were supported with their cultural and religious needs.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The governance structure in place had not identified areas of concern found during the inspection.
- The provider had no assurance framework to ensure services were being appropriately managed.
- Organisational policies did not reflect changes in legislation or good practice guidance.

However:

- Staff felt supported by the management team.
- Human resources procedures were thorough and correctly followed.

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.

The provider had a Mental Health Act administrator who supported the hospital with the appropriate implementation of the Mental Health Act. Staff received Mental Health Act training as part of their mandatory training requirements and had a good understanding of the Act. Mandatory training for Mental Health Act was low with rates of 64% of qualified staff and 67% of support staff who had completed it at the time of inspection..

The documentation in respect of detention under the Mental Health Act was good. Paperwork about patients' detentions and leave was up to date and stored correctly. On Cavendish ward we found that patients were not having their rights explained to them when they were admitted and this did not always happen until several weeks after admission.

Regular audits were carried out to ensure the Act was implemented correctly, however these had not identified the concerns regarding the consent to treatment. There were five patients prescribed medication not covered by the correct form of authorisation or consent. One patient had a T2 form in place which did not authorise all prescribed medication. Four patients had T3 forms in place which did not authorise all treatment. Of the patients with T3 forms, two of the patients had not been given the medication but two had been. These issues were raised with the management team at the time of the inspection. (A T3 form is a certificate of second opinion used to support decisions around care and treatment being provided to a patient who did not have capacity to understand the effects of the medication. A T2 form is a certificate of consent to treatment used to record that the patient has capacity to provide consent and understood the care and treatment decisions which have been made. These documents are part of the statutory documentation used to lawfully comply with the Mental Health Act 1983.) A patient on Cavendish ward had a T3 in place with instructions for a section 61 review of treatment to be made at a specific time which had not taken place.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found the hospital was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLs).

We found evidence of capacity assessments and the recording of best interest meetings within the care records we looked at.

Most staff understood their roles and responsibilities with regards to the Mental Capacity Act and Deprivation of Liberty safeguards.

There were 91% of qualified and 82% of support staff at the hospital who had completed the Mental Capacity Act mandatory training which included consent.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe and clean environment

Clinic rooms were organised well. Fridge temperatures and room temperatures were completed and in normal range. Medicines reconciliation checks were carried out with no errors.

Resuscitation equipment was present and checked regularly.

There were ligature points in the form of taps, window closures and door fittings. The registered manager completed environmental risk assessments and ligature risk assessments for the hospital. The registered manager completed these on a six monthly basis with the last assessment for the environment on 29 February 2016 and the ligature risk assessment on 30 January 2016. The risk assessment did identify a number of ligature and environmental risks but this information was not shared with staff. This meant that staff at ward level were not aware of the identified risks or actions needed to minimise the risks.

The wards and communal areas were clean throughout the hospital. Cleaning records were up to date and demonstrated that the environment was regularly cleaned. Staff completed audits on hand hygiene, mattresses within the hospital and infection control every year. Where actions were identified, these were assigned to a person and monitored. The hand hygiene audits showed that staff who took the annual test all passed the assessment.

Staff followed infection control principles, with gloves and aprons available for clinical use. We saw staff using the antimicrobial hand wash which was available in wall dispensers throughout the service. During mealtimes, staff wore appropriate aprons and hair coverings.

There was a swipe card access system throughout the hospital; patients who were not detained under the Mental Health Act were issued with a swipe card to enable them access in and out of the hospital. Authorised staff had cards issued through an internal security system. There was a swipe card audit completed on an annual basis. Staff were also issued with portable alarms to alert other staff to incidents and when help was needed in an emergency.

Safe staffing

The service reported the following staffing details for the period 30 November 2014 to 21 October 2015:

Total number of substantive staff was 44 which included 14 qualified and 30 support workers

Total number of substantive staff leavers in the last 12 months was 9

Total percentage of turnover of all substantive staff leavers was 22%

Total percentage vacancies (excluding seconded staff) was 18%

Total percentage of permanent staff sickness overall was 2%

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The service reported their use of bank and agency staff for the period 01 January 2016 to 31 March 2016 as follows:

Agency qualified - 132 hours to cover vacant posts

Agency support worker – 883 hours

Bank qualified – 37 shifts

Bank support workers – 97 shifts

Although the use of temporary staff was high, agency nurses were block booked and had an induction before they worked on the wards. This meant that there was a continuity of care and consistency of staff who provided care to patients.

The hospital staffing establishment took into consideration the skill mix for each ward. There was a core staffing level with additional staff being added to support increased observation levels for activities such as escorted leave or trips.

The rota was prepared jointly by the registered manager and the general manager to ensure appropriate skill mix and allocations for increased observations. There was a minimum staffing ratio of one qualified nurse and two support workers to each day and night shift for all wards. We were told that staffing levels were increased above this to cover increased observation levels as required. Staffing levels could be adjusted by one of the management team to take account of changed risks or circumstances. We saw this on Cavendish ward; there had been an incident on the Monday of the inspection week where a patient had become distressed. To support the increased observations of patients and promote a more settled atmosphere on the ward, the management team arranged additional members of staff for the evening shift and the following day and evening shift.

There were two psychiatrists who worked at Jigsaw but at the time of the inspection one was on maternity leave. This meant that only one psychiatrist was undertaking the ward rounds for all patients at Jigsaw and ward rounds took place every two weeks. Out of hours cover there was an arrangement on a rota basis for several services, this was provided by medical staff familiar with the services. There was also out of hours GP provision although we were told the first contact tended to be to the out of hours psychiatrist.

Staff undertook mandatory training at induction and had refresher training appropriate to the course either annually, every two or three years as required. The provider gave us figures for training rates in March 2016. There were 16 mandatory training courses with a target of 75% achievement. Training rates were below target infourcourses for qualified staff and five courses for support staff.

For qualified staff, attendance below 75% was for immediate life support (64%), safeguarding (72%), Mental Health Act (64%) and equality and diversity (64%). For support staff, course attendance below 75% was for first aid (including basic life support) (65%), fire awareness (70%), positive handling intermediate (73%), Mental Health Act (67%) and equality and diversity (67%).

The number of staff trained in immediate life support and basic life support were below target which meant there was a risk that sufficient numbers of staff with life support skills may not be available should a patient require assistance.

Assessing and managing risk to patients and staff

Patient's risks were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenged. Patients were involved in managing risks and risk assessments. Jigsaw had recently implemented the "my shared pathway". My shared pathway is a way of planning, following and managing a patient's stay in a secure hospital. My shared pathway aims to ensure that patients work together with staff to identify, clarify and work towards the required outcomes or 'achievements' that will enable patients to leave secure care and move back into the community.

Risk assessments were completed on admission to the service and regularly reviewed to reflect any changes in risk. Although the four care records we case tracked contained risk assessments which were updated following any identified changes and a full review was held within the ward round, some of the risk assessments were from their previous placements. The risk assessment tools used at Jigsaw were the individual risk mitigation process and the historical clinical risk management - 20. Staff only received training in the use of the historical clinical risk management -20. The information contained in the risk assessments was basic and did not always contain interventions.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Blanket restrictions were in place on two wards. On Linden ward the kitchen was locked so patients had to ask staff to access the kitchens to make drinks and cutlery was locked away in the kitchen and only used at mealtimes. The crockery and cups were all strengthened plastic, this was in response to an incident and risks associated with one patient on the ward. The kitchen and dining room were locked on Cavendish ward where patients were not allowed to make hot drinks even with staff supervision. Individual risk assessments for most of these patients did not identify that there were any risks involved with them making hot drinks.

Patient records did not contain details of care and treatment provided by the GP, which meant that information about patients' health would not be available on the ward in an emergency.

The hospital had no seclusion room and had reported no incidents of seclusion or segregation for the period 1 May 2015 to 31 October 2015. De-escalation techniques were used when required to support patients. Staff had personal alarms for safety. Staff told us that they knew the patients and their triggers which meant they could recognise if a patient's mental health was deteriorating before it became a crisis.

Montrose ward had reported two incidents of restraint between 1 May 2015 and 31 October 2015, both of which involved the same patient.

Cavendish ward had reported 10 incidents of restraint recorded between 1 May 2015 and 31 October 2015, which involved two patients.

Linden ward had reported no incidents of restraint recorded between 1 May 2015 and 31 October 2015. None of the restraints on any of the wards had been in the prone position.

Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. The provider had a safeguarding policy and procedure in place. Safeguarding alerts were recorded on the incident reporting forms and reported to the local authority teams as required. As part of the inspection process we reviewed alerts and concerns which had been raised by Jigsaw. Between 10 January 2014 and 30 December 2015 there had been one safeguarding alert raised and 26 safeguarding concerns reported to CQC.

Jigsaw had good working relationships with the local authority safeguarding teams. Staff knew the process for reporting any safeguarding concerns and had contact details.

There were 72% of qualified staff and 82% of support workers at Jigsaw who had completed their safeguarding vulnerable adult's mandatory training.

Medicines were not managed safely.

On Montrose ward, there was no medicines disposal bin available, and medication was being placed in bags awaiting disposal by pharmacy.

Patients were not always getting their medicines as prescribed. In one instance, staff were administering an antibiotic medication four weeks after the stop date. This was immediately brought to the attention of the staff to ensure the medicine was disposed of and not given to the patient. In another instance, staff had not made arrangements to ensure that a patient was getting their medicine when the patient was carrying out a voluntary work placement on a weekly basis. This was medication which needed to be taken with food for diabetes. Staff were recording the dose as missed as the patient was on leave.

One patient was prescribed a benzodiazepine as a hypnotic, a medicine used to help someone sleep but the patient had missed two doses as the drug was out of stock.

On Montrose ward, the fridge contained ibuprofen gel from 2014, which was both out of date and stored incorrectly. Records did not show whether the gel had been administered when out of date.

Three patients were prescribed high doses of antipsychotic medication which was above the limits recommended in the British National Formulary. The British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing including maximum therapeutic limits. None of the three were identified as needing increased monitoring as a result of high dose treatment and there were no guidelines for high dose antipsychotic treatment and monitoring in the medications policy.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Nine patients were prescribed rapid tranquillisation which had not been used but also not been reviewed. This meant that medicines were not being reviewed regularly to check whether they were still needed. The service did not have a policy for rapid tranquilisation.

Track record on safety

Jigsaw hospital had reported one serious untoward incident within the last 12 month period. This occurred in July 2015. The incident took place on Cavendish ward and was classed as a type three incident (a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including property damage). An investigation and learning from the incident had been undertaken.

Reporting incidents and learning from when things go wrong

All staff were aware of the procedure for reporting incidents and how to complete an incident form. All staff completed incident forms and we saw examples of these as part of the inspection. Between January and March 2016, staff had reported 57 incidents.

The incident reporting was recorded using the incident / accident matrix system. Registered managers were able to report from the system by category of incident, by patient or by ward to review themes.

The registered manager advised us that debriefs took place following an incident or at the end of a shift. Staff confirmed this when we spoke with them and they advised there was adequate support.

Duty of candour

When things went wrong, we did not find that patients or carers were informed or that there was a culture of openness and transparency, to meet duty of candour requirements.

There was no duty of candour policy in place at the time of the inspection.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed care records for six patients and case tracked four. Records did not include detailed history from previous placements, which meant that there was a risk that important information would be missed. The hospital had recently introduced my shared pathway but this required further embedding as records contained basic information and did not include the patients' perspective. Care plans were not recovery focussed and lacked any formulation or sense of direction, outcomes or discharge planning in any of the files we reviewed.

In three of the four files, there were no minutes from care programme approach meetings which meant that there was a risk that actions would not be followed up and this could delay progress and discharge.

There were no crisis plans in patients' care files. This meant there was a risk that staff would not be aware of how to respond to individual patient distress in order to avoid escalation.

Staff used a number of tools to assess and support patients including my shared pathway, health of the nation outcome scales and historical clinical risk management -20.

The service did not have a clear statement explaining its admission criteria and how it would support patients with their rehabilitation. This meant it was hard to measure whether the hospital was achieving its goals in terms of the outcomes for patients.

Pre-admission assessments did not always identify patients' complex needs. We saw that staff's use of restrictive practices to manage one patient's unanticipated risks had an impact on the other patients on the ward.

Patients were registered with local GPs who looked after their physical health care needs. Access to physical healthcare was generally via the GP service. Patients were registered with one of three local GP practices. Home visits could be arranged if needed although most patients were seen at the practice. The notes from GP consultations were held within the GP records and no copies were available in the hospital notes.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Care records were stored securely on the wards in the office in lockable cabinets. All staff held keys to gain access to patient records.

Best practice in treatment and care

The provider had a process in place to disseminate National Institute for Health and Care Excellence guidance information via the governance structure and local meetings. However, this was not effective.

Medication was not prescribed and reviewed in line with National Institute for Health and Care Excellence guidance. The hospital had no system for identifying and monitoring when patients were prescribed high dose antipsychotics. An example of this was three patients were prescribed high doses of antipsychotic medication which were above the limits recommended in the British National Formulary. None of the three were identified as needing increased monitoring as a result of high dose treatment and there were no guidelines for high dose antipsychotic treatment and monitoring in the medicines policy.

Psychological interventions were not readily available. There was a limited resource and most of the psychological assessments and interventions were undertaken by an assistant psychologist available for two days a week. We saw no evidence of psychology input, either individual or in terms of ward round summaries, in the records we reviewed. We were told this was because psychology case notes were held separately. Referrals for psychology input were made by the responsible clinician.

The provider's scheduled programme of audits did not include any audits that benchmarked practice against National Institute for Health and Care Excellence guidance.

The six Cs were displayed on a notice board within the reception area. The six Cs are values and behaviours central to NHS England's Compassion in Practice which was launched by NHS England to improve care. The six C's are care, compassion, competence, communication, courage and commitment.

Skilled staff to deliver care

Multidisciplinary team care was comprised of medical, occupational therapy, psychology and nursing staff.

There were two psychiatrists who worked at Jigsaw but at the time of the inspection one doctor was on maternity leave. No cover had been arranged and this meant that one psychiatrist was undertaking the ward rounds for all patients at Jigsaw in the same amount of time normally available. Some patients told us that they struggled to see the doctor outside of their fortnightly ward round. We discussed this with the registered manager who advised that patients were able to request to see the doctor in between ward rounds.

There was limited access to psychology; patients told us that they had limited sessions with psychology. This was also noted on reviewing the care files for patients, where there was no clear direction of a therapeutic model of care or holistic approach.

A full time occupational therapist provided group and individual interventions and was assisted by two occupational therapy assistants. Although there was an activities programme on offer, not all patients were fully engaged with it.

There was no access to a clinical pharmacist or a service based social worker.

The provider had a supervision policy in place. The policy provided a structured process and ensured involvement in the process to understand the roles and responsibilities in relation to supervision. The policy outlined that the expected frequency of supervision sessions was that they should occur four-six weekly, with individuals receiving no less than six sessions over a 12 month period. However we found that rates of supervision were low for support workers with 60% (18 of 30) having received supervision. Supervision rates were higher for qualified staff with 71% (10 of 14) staff having received supervision.

Not all staff had received an appraisal. At 1 April 2016, 39% (17 of 44) of staff had received an appraisal in the previous 12 month period. This meant that staff were at risk of not understanding clear objectives, reviewing their development or receiving the required training for their role. Both doctors had been revalidated.

Staff at Jigsaw were supported with specialist training, however training rates were low for all courses except training for Health of the Nation Outcome Scales. There was no training for patients with challenging behaviour.

Personality disorder training

14% (2) qualified

23% (7) support workers

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Historical clinical risk management- 20

29% (4) qualified

33% (1) psychology assistant

33% (1) occupational therapist

Risks for sexual violence protocol

29% (4) qualified

33% (1) psychology assistant

33% (1) occupational therapist

Autism training

34% (15) staff in total

Diabetes training

14% (6) staff in total

Epilepsy training

21% (3) qualified

Shared pathway training was also provided to staff. Figures were not available to show how many staff had received this.

Multidisciplinary and inter-agency team work

Multidisciplinary team meetings or ward rounds took place every Wednesday.

There was a daily nurse handover meeting where nurses shared the details of the patients' presentation, any incidents, increased risks or medication details. There was also a hospital allocation planning meeting where staff allocated particular duties for the shift.

The service had good links with local commissioners, the local mental health trust, and the local authority safeguarding team. External stakeholders said they were kept up to date on patients' progress.

Adherence to the MHA and the MHA Code of Practice

The services had systems in place to assess and monitor risks to individual patients who were detained under the Mental Health Act however these were not effective.

Hospital managers' hearings were not routinely held at renewal of detention for each patient. One patient had been detained at the hospital for four years and the last hospital managers hearing was held in October 2014.

Another two patients had their sections renewed at the beginning of March 2016 although there was no documented evidence that a hospital managers hearing had taken place or was planned for either patient.

Although section 17 leave documentation was well completed, there was no evidence that copies had been offered to the patients.

Section 58 of the Mental Health Act sets out the circumstances in which medication or treatment can be given to patients without their consent. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate of second opinion completed by a doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.

There were five instances where additional medication had been prescribed which was not authorised by the T3 form. A patient on Cavendish ward had a T3 in place with instructions for a section 61 review of treatment to be made at a specific time which had not been done.

Two T2 forms were dated 2014, when it is good practice for these to be reviewed every year.

Care programme approach minutes were missing from three out of four files we reviewed.

Mandatory training for the Mental Health Act was low with rates of 64% of qualified staff and 67% of support staff who had completed it at the time of inspection in March 2016.

Patients had their rights explained to them every three months or as identified by any changed or renewals of their section and staff recorded this.

Policies and procedures did not reflect the current code of practice for Mental Health Act.

Patients had access to the independent mental health advocate who attended the hospital on a weekly basis.

Good practice in applying the Mental Capacity Act

None of the patients were subject to Deprivation of Liberty Safeguards.

Staff had an understanding of the principles of the Mental Capacity Act, in particular, about the presumption of

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

capacity and its decision-specific application. Staff knew they could consult with the mental health administrator for further advice and information. The provider had a capacity policy for staff to refer to and support following training. Although staff were trained on the Mental Capacity Act, understanding was variable. At 30 March 2016, 91% of qualified and 82% of support workers had completed their training for mental capacity.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

There was variable feedback from patients about staff. Feedback from patients was generally positive about the way staff treated them. A small number of patients told us they did not like being cared for by some agency staff. Patients told us that they did not feel there was a focus on rehabilitation and there was no input from psychology. Some patients wanted to see the doctor more. On one ward, patients complained about the blanket restrictions put in place in response to one patient.

Most patients told us they were treated with dignity, respect and kindness during all interactions with staff. Generally we observed good interactions between staff and patients during our visit.

Patients told us staff understood their needs and respected their privacy and confidentiality. However, we did observe one interaction on Cavendish Ward where the staff member had not understood a patient's trigger to her frustration as she had missed her smoke break. The nurse in charge took immediate action and ensured the patient was supported to have a cigarette.

The involvement of people in the care they receive

Patients were involved and encouraged to be part of their care and treatment decisions with support when it was needed.

Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were supported to maintain and develop their relationships with those close to them, their social networks and community.

Although patients were given copies of their my shared pathway, they did not include the patient's views.

Patients were provided with independent advocacy services who attended the hospital on a weekly basis. The advocate also led the patient community meetings and undertook a selection of patient surveys.

We attended one community meeting which was chaired by a patient. The meeting lacked structure and focus, only two patients attended and the meeting lasted 10 minutes.

There were notices on patient boards encouraging patients to talk to the registered manager and patients could complete feedback forms.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Requires improvement

Access and discharge

At the time of the inspection there were 24 patients at the hospital, with 23 being detained under the Mental Health Act and one patient who was informal. Informal patients were issued with a swipe card for free access in and out of the hospital. Patients were placed from four different clinical commissioning groups. One was out of area but the others were local.

The registered manager received the information regarding new referrals. Managers reviewed the referral information and often the general manager and clinical nurse manager would undertake an assessment.

There was a process in place to admit patients to the hospital however it was not supported by referral criteria. This meant it was difficult for the hospital to assess if they were able to meet a patient's needs. We were told that referrers often gave limited historical information however there was no system in place of not accepting a referral until all the information was in place.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We saw where the admission assessment had not worked.. Since the admission, there had been an increase in the number of incidents. In response to this, staff had imposed blanket restrictions. Other patients were very unhappy with the disturbance on the ward since the patient's admission. One patient told us the ward felt higher security than the low secure ward they had been admitted from.

Jigsaw independent hospital reported one delayed discharge on Montrose unit in the period between 1 June 2015 to December 2015; the reason was awaiting an appropriate move on placement.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had three wards which were currently open. There was a range of rooms to support patients' involvement in activities, therapy rooms, kitchenette and main TV lounge areas. There was very limited access to quiet rooms on all three wards. On Linden ward there was one quiet room which doubled as an area for destimulation. We saw the advocate having to see a patient in the kitchen. On Cavendish ward, the quiet room was being used as a storage room during its refurbishment as a sensory room. Patients were mainly in one communal lounge with limited options for quiet space other than the dining room. On Montrose ward, there was no quiet room. There was a lounge and a dining room which was used for activities. There were rooms where patients could take their family and visitors for privacy which were off the ward. There were also quiet rooms available and access to a garden area. On Linden ward the kitchen was locked and on Cavendish ward there was no direct access to hot drinks and snacks. There was a timetable for making hot drinks although staff told us they would make drinks for patients at other times.

Patients had access to their bedrooms throughout the day and had keys to their rooms. Patients were encouraged to personalise their rooms and our inspection team were shown rooms by the patients.

Meeting the needs of all people who use the service

Information was available for patients, carers and family members. Information was available on advocacy services for patients to access help and support.

The registered manager advised us that interpreters were available if required so that patients, family members or carers could understand what care and treatment was being provided.

We were also told how patient's cultural and religious requirements could be supported and this was confirmed when we spoke with patients.

Listening to and learning from concerns and complaints

Complaints were usually addressed at a local level to attempt a resolution. Such processes as "talk to registered manager" was available for patients, their family members or staff. If a local attempt at resolution failed then it was escalated through the provider's formal complaints process. There was a complaints policy and procedure in place to support this process.

As part of the inspection process we reviewed six formal complaints, the responses from the provider, the investigation reports where applicable and the outcome of the complaint. All complaints reviewed followed the complaints policy and were managed appropriately in line with the guidance.

Jigsaw hospital maintained a record of informal complaints or concerns to show actions which had been taken and if the vulnerable adults policy needed to be considered. Informal complaints made by patients were followed up with a letter from the registered manager to confirm the discussion and outcome, and gave the option to trigger the formal process if the patient was unhappy with the outcome.

There was one complaint received at Jigsaw independent hospital in the 12 months ending in December 2015. This complaint was upheld, and as a result of this complaint there was a system review and update to ensure there was no reoccurrence.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Vision and values

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The statement of purpose contained aims for the service rather than specific visions or values.

Staff were not aware of a corporate vision or values, but told us of their own values and reasons for working in the service.

Management staff told us about specific initiatives such as the 6 Cs which included the principles of care, compassion, commitment, communication, courage, and competence that they followed as an organisation.

Good governance

The provider did not currently have an assurance framework or business plan although a recent restructure within the organisation meant that this was something which was being developed. There was a quality initiatives document which outlined key areas for focused development with timescales. Policies and procedures were used across the provider organisation which included a sister hospital. The risk register for the sister hospital identified that policies and procedures required updating. This had not been shared or actioned across the provider's locations via the governance structure.

The head of contracting produced a report for the board; this looked at the monthly occupancy by commissioner and forecasting occupancy figures. The head of contracting prepared a draft contracting strategy and action plan which was being reviewed by the board. This enabled the provider to monitor and manage the bed availability within Jigsaw.

The registered manager produced a monthly hospital performance report which provided assurance to the board on progress against a range of key performance indicators. The report was a summary of the month's performance using key indicators of number of vacancies, average sickness rate for the month and showed the last six month's figures for trend analysis, new starters, staff leavers, budget management for over spend, accidents and incidents with the along with notifiable events, completed audits, complaints received, infection control, external inspections and any other business to report to the board. The report included little detail and had not identified the concerns we found. This report did not monitor the medication management and Mental Health Act compliance to provide the board with assurances of safe administration of medicines and lawful detention of patients sectioned under the Mental Health Act.

The provider's governance policy was not effective. The governance systems had not identified the areas of concern which we found during the inspection process; these included missed medication, accurate management of the T2 and T3 forms for mental health act administration, awareness of the environmental risk registers by ward staff and low levels of achievement for mandatory training, specialist training, supervision and appraisals.

Policies and procedures did not reflect the current code of practice for the Mental Health Act or Department of Health and National Institute for Health and Care Excellence guidance on reducing restrictive interventions.

The provider had an annual audit plan which had been compiled in November 2015 to commence January 2016. The plan outlined 38 audits to be completed on various stages of the year between January to December. Areas on the plan included: environmental and security, cleanliness and equipment monitoring, care and treatments records, medication records, staff management and support, incidents and accident recording, complaints, infection control and human resources.

We reviewed five audits that had been completed in January and February 2016. All audit tools had supporting action plans where required or feedback information for actions to be taken.

The registered manager for the location was responsible for the local risk registers. They managed the identified risks, rated them, and these were discussed and agreed at the governance meeting. The risk register was rag rated green amber and red, with red being a high risk. In November 2015 there were nine risks on the Jigsaw register of which three remained at an open amber level, all the other risks had been recorded as resolved and closed. The risks still open did not reflect what we found on inspection.

The risk register items open and rated as amber level were the governance system had identified an increased number of incidents of physical aggression towards peers and staff due to a patient being inappropriately placed and their needs not being met. It was clear on the risk register how and what controls had been put in place to support delivery of care. This included additional staff on the ward and a professionals meeting. This was ongoing on the risk register as it had been decided this hospital was not appropriate and a suitable placement was being sought.

The second risk register item open and rated as amber level was an identified medication reconciliation error when staff were booking in the medication it was not the medication provided in the box. Clear controls and actions listed on to minimise the future risks.

The third risk register item open and rated as amber level was the broken lift at the hospital. Clear controls and actions listed on to monitor the performance of the lift and work with maintenance.

The information governance toolkit is a Department of Health Policy delivery vehicle that the Health and Social Care Information Centre is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by Department of Health policy and presents them in in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance. The toolkit attainment levels range from level 1 to 3, with 3 being the highest. The provider had recently introduced the information governance toolkit and was aiming to complete this by 31 March 2016 to achieve a level two. This would be their first rating for the information governance toolkit as it was their first submission. Once the process had been completed by 31 March 2016 there was a requirement for the organisation to continue to meet an annual self-assessment against compliance. To support gaining this achievement the provider has an information governance steering group. The provider has also appointed the roles of a Caldicott Guardian, a senior information risk owner and a lead for information governance.

Fit and Proper persons test

The Fit and Proper Person Requirement is a regulation that applied to all independent health providers from April 2015. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role. Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a disclosure and barring service check and a full employment history).

The provider had a Fit and Proper Person Test policy to meet the requirement. The measures and declaration were implemented in May 2015. The policy established a process to monitor the provider was meeting its duty. We reviewed the files of three executive and non-executive directors and all contained the required information**.** There was a system in place to ensure that this was reviewed annually.

Leadership, morale and staff engagement

Staff reported being happy in their roles and felt supported by their teams, immediate managers and the operations director. Staff told us that the registered manager had an open door policy and they were able to ask for support when needed. We found consistent feedback that senior managers listened to staff, including their ideas for service development.

The results from the staff survey from October 2015 supported this. There were 84% of staff who felt their line manager listened to the views and opinions of others; 81% of staff felt they worked as a team; 65% of staff felt the performance of the team had improved in the last six months; 81% of staff felt supported by the clinical nurse manager; 86% of staff felt supported by the general manager and 92% of staff felt supported by the registered manager.

Sickness and absence rates were low at 2%, although there were a high number of leavers reported with a staff turnover of 22%. There was also a high vacancy rate of 18%. We reviewed the three most recent exit interviews following resignation and the process of completion. Human resources undertook the exit interview process and completed audits or action plans to follow up on the areas raised.

There were policies in place to address all aspects of staff management and performance.

We reviewed four staff recruitment files, one file of a staff member being managed under the sickness policy and two files where staff members were being managed under the disciplinary policy. The reviews showed the appropriate

organisational policy was followed and issues were dealt with promptly. They also had no grievances being pursued, no performance management monitoring and there were no allegations of bullying or harassment.

Jigsaw had raised one concern about staff conduct which had been reported to a professional body.

The provider had a whistle blowing policy in place. The operations director advised during an interview that this would be re-visited to support staff awareness following a recent concern raised. It seemed that staff were not aware of the internal process for raising concerns.

The provider used a number of ways to gather feedback from staff, carers and patients which included surveys, home visits to family members or carers, forums such as the community practice forum; this was a new forum which has been set up to look at all aspects of sharing best practice and involving all levels of staff and professionals, including external stakeholders. The forum talked about best practice, shared good practice, looked at what was working and what was not working to foster a more collaborative working.

Commitment to quality improvement and innovation

The provider worked across four commissioners based on a spot purchase rather than a contract basis. Contracts were in place with some commissioners and monitoring data was produced to support the contract. Governance arrangements with regards to commissioner contract monitoring meetings were set up for the commissioners where contracts were in place. A monthly contract monitoring meeting took place between the provider and the commissioners. The contract meeting supported the monitoring of quality care being delivered by the service and that it was within the with the agreed contract terms.

Jigsaw did not participate in any national accreditation schemes such as Accreditation for Inpatient Mental Health Services (AIMS).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must review the blanket restrictions applied within Linden and Cavendish ward to ensure patients are cared for with the least restrictive practice
- The provider must ensure that appropriate medication disposal bins are available within the wards
- The provider must ensure that systems are in place to monitor the storage of medication and expiry dates
- The provider must ensure that patients receive medicines that are prescribed for them and where required the appropriate consent form (T2) or form of authority (T3) is in place
- The provider must review the medication policy to ensure staff have guidance in relation to high dose antipsychotic treatment and rapid tranquillisation
- The provider must ensure that care plans are recovery focussed and patient centred, with clear outcomes identified
- The provider must ensure that pre-admission documentation supports the clinical decision to admit a patient into the hospital using a clearly defined assessment process and service admission criteria
- The provider must ensure that there is a collaborative multidisciplinary care approach which is focused on discharge planning
- The provider must review the level of psychological interventions to ensure patients' needs are being met and care is being delivered in line with best practice
- The provider must ensure that records of care programme approach meetings are kept to ensure that all actions are completed.
- The provider must ensure that all staff are aware of the Duty of Candour and produce guidelines to support staff in implementing this
- The provider must ensure that physical health passports include all records or copies of investigations and treatment undertaken by the GP
- The provider must review all Mental Health Act policies and revise in line with the Mental Health Code of Practice 2015
- The provider must put plans in place to ensure staff are aware of ligature points within ward environments and mitigation plans for these
- The provider must ensure that all staff are up to date with mandatory and specialist training and receive supervision and appraisals so that they can carry out their roles effectively.
- The provider must review the governance arrangements in terms of information assurance
- The provider must review the audit arrangements particularly in relation to the issues identified in this inspection

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should review the level of psychiatrist cover to ensure that patients can see a doctor when necessary.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care** There were blanket restrictions in place with patients not allowed access to kitchens and • there was no collaborative multidisciplinary approach in delivering care. • Care did not include appropriate levels of psychological interventions to meet people's needs. • Care records did not hold evidence to support the patient's goals with care and treatment being focused on discharge. • There was no admission process which clearly supported the service provision for rehabilitation care and treatment. This was a breach of regulation 9 (3)(a)(c)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Regulation 17 HSCA (RA) Regulations 2014 Good Governance

- There was no system to ensure all records were maintained. Copies of care programme approach meeting minutes were missing from three out of four files reviewed
- Information regarding the patient's physical health care provided by their GP was not included in patients' health passports.
- There was no system in place to ensure all organisational policies and procedures reflected the appropriate national guidance.
- Mental Health Act policies had not been updated to reflect the current code of practice.
- Practice had not been reviewed in line with the new Code of Practice.
- There was a comprehensive audit programme in place but this had not been effective in identifying areas of concern in relation to the Mental Health Act or medicines

  management.

This was a breach of regulation 17(2) (b)(c)

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 20 HSCA (RA) Regulations 2014 Duty of candour **Regulation 20 HSCA (RA) Regulations 2014 Duty of Candour** • Patients and their relatives were not informed of errors when they were identified. • There was no duty of candour policy in place. This was a breach of regulation 20
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 **Regulation 18 HSCA (RA) Regulations 2014 Staffing** • Training rates were low in some of the mandatory courses and all specialist training. Not all staff were being supervised with only 60% of support workers and 71% qualified staff receiving supervision. Only 39% of staff had received an appraisal. This was a breach of regulation 18 (2)(a)

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
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 **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** • Patients were not always receiving medicines as they had been prescribed. • Medication was not stored appropriately which meant that patients were at risk of being given medicines which were not effective. • Medicines were not being disposed of safely. There was no medication disposal bin in a clinic room and staff were disposing of medicine in a plastic bag which was not safe. Patients who were on high dose antipsychotics were not being monitored to check for any adverse effects. Patients were being prescribed medicines which were not included on the form for consent (T2) or form of authorisation (T3). • Environmental and ligature risk registers were completed but not shared with staff on the wards. Staff were not aware of the risks or how to manage and lessen the risks to patients.

This section is primarily information for the provider

Enforcement actions

This was a breach of regulation 12 2 (b) (g)