Lakeside View

Quality Report

1 Ivydene Way
Willenhall
WV13 3AG
Tel: 07557376134
Website:

Date of inspection visit: 13 and 18 January 2017
Date of publication: 29/03/2017

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 following issues that the service provider needs to improve:

- Staff did not follow the guidance in place to direct medical and nursing staff in safely administering intramuscular rapid tranquilisation. This meant that patients could be at risk of significant harm.
- The multi-disciplinary team reviewed incidents. Incidents reported demonstrated high numbers of restraint and self-harm. Staff told us there was limited support and debriefs following incidents. Staff told us they did not always feel the learning from incidents were fully embedded.
- Staff had not followed local protocols or provided documentary evidence of reviews when using restrictive interventions such as using safe wear clothing and bedding.
- Patients provided information within their care plans to help staff know and understand their preferences. For example, to reduce distress and agitation. However, staff did not always use all the information contained within the care plans. This meant patients might experience unnecessary distress.
- Staff and patients expressed that dignity was sometimes compromised. For example, patients had

Summary of findings

to request toilet paper and were allocated specific number of sheets. When staff assessed patient's clothes as a risk, paper underwear was used; sometimes they ran out.

- Lakeside View was a new service with new staff. Staff backgrounds varied and the majority of staff did not have experience of working on personality disorder inpatient wards. There were good staff inductions; however, personality disorder specific training was limited. There was a commitment to supervision but it was not consistent and the content of the sessions differed between those carrying out the supervision.
- There had been a high number of bank and agency staff, which could adversely affect patient care, treatment, and safety.

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

- There were a number of safety systems on the ward to reduce the risk of harm to patients and staff. For example, a pinpoint alarm system so that staff could respond to emergencies. Managers had carried out environmental and ligature audits. Staff recorded incidents well.
- There were risk reviews for individual patients and the implementation of risk management plans to keep patients safe. There were a number of methods in use to reduce the incidence of significant harm to patients. For example, the use of one to one observations.
- Care plans were written and reviewed involving key people who played a part in the patient's recovery. They were often adapted to meet the dynamic needs of the patients. The care plans evidenced encouragement of independence.
- Families and carers spoke with positivity about their experience with the service. They were particularly impressed with the communication and support they received from staff at Lakeside View. All carers told us that they were impressed with the progress they had observed.

Summary of findings

Contents

Summary of this inspection

Page

Background to Lakeside View 5

Our inspection team 5

Why we carried out this inspection 5

How we carried out this inspection 5

What people who use the service say 6

The five questions we ask about services and what we found 7

Detailed findings from this inspection

Mental Health Act responsibilities 9

Outstanding practice 16

Areas for improvement 16

Action we have told the provider to take 17

Lakeside View

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

Summary of this inspection

Background to Lakeside View

Lakeside View is a new locked rehabilitation service for young women transitioning from adolescent to adult services. It is designed specifically for people between the ages of 18-25 years. The hospital opened for admissions in August 2016.

Lakeside View has 24 beds comprising of a 12 bed unit, an 8 bed unit and a 4 bed unit. Only the 12 bed unit was in use at the time of inspection.

The service is built to manage complex needs in a safe and therapeutic environment to support and promote independence according to progress and changing needs.

Patients have individual programmes and structured treatment. The service supports patients with building life skills and the transition into adulthood.

It is a service for young women with a diagnosis of mental illness and personality disorder who present with challenging behaviours including self-harm. They may be detained under the Mental Health Act (1983), be subject to Ministry of Justice Restrictions or Deprivation of Liberty Safeguards.

Our inspection team

The team was comprised of two CQC inspectors, two inspection managers, one Mental Health Act reviewer and one CQC pharmacy inspector.

The lead CQC inspector was Beth Houston.

Why we carried out this inspection

This was Lakeside View's first inspection, which was unannounced. We did not complete a comprehensive inspection; instead, we focused on the safe and caring domains. At our initial inspection, we were concerned about some of our findings. This prompted a further unannounced inspection the following week. At the second inspection, we took a specialist CQC pharmacy inspector and a Mental Health Act reviewer. The report outlines the overall findings; however, we did not rate the service.

A comprehensive inspection is planned for 2017 and this is when Lakeside View will be rated.

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.

During the inspection visit, the inspection team:

- visited one ward, which was the only ward in use at the hospital
- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service and two carers

Summary of this inspection

- spoke with the hospital director, nurse in charge and ward manager
- spoke with the consultant psychiatrist, one nurse, one psychologist and two health care assistants
- attended and observed one hand-over meeting
- looked at five care and treatment records of patients
- looked at five staff members personal files
- carried out a specific check of the medication management on the wards and looked at six of the seven medication charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Feedback from patients on the ward was mixed. Two of the five patients told us that staff were kind and one patient told us that the permanent staff were good. All patients told us there were high numbers of agency staff and they felt the agency staff were less engaged.

We spoke with two carers; both spoke very highly of the service. They told us they felt there had been significant improvements in the care received compared to children's services. For example, better communication, greater involvement in decision-making and both carers knew how to make complaints.

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?

- There were a number of leavers since the ward opened and a number of new staff on the ward. There was a recent recruitment drive that meant there would be more staff that were new. Staff files indicated that new staff on the ward did not come with professional experience of working with the complex patient group. New staff received a two-week induction, however the personality disorder element of the induction lasted one and half hours. This would not provide staff with sufficient skills to work with patients with a personality disorder on an inpatient unit.
- Arrangements were in place to provide guidance to medical and nursing staff to administer intramuscular rapid tranquilisation. Staff did not always comply with the written guidance documented within the care plans to administer this medication. This meant that patients could be at risk of significant harm.
- Lakeside View had a significantly increasing number of incidents from October 2016 to January 2017. There had been a significant month on month rise in the incidence of restraint and patient on staff assaults on the ward. This could have an impact on staff and patients. We saw limited staff support and debriefs following incidents. There were however very good incident reporting systems in place and some scope to carry out audits to reduce the number of incidents.
- There were no qualified nurse vacancies. Health care assistant vacancies had been recruited to. However, there had been a high number of agency staff used in addition to bank staff. Patients and staff reported that this could adversely affect patient care, treatment, and safety.
- People on the unit did not have accessible hand sanitisation to prevent and control the potential to spread infections.
- There was a cleaner on site most days; however, some of the floors on the ward and patient bathrooms were not clean.

However:

- The ward had a pinpoint alarm system. This meant that staff could respond immediately to an emergency.

Summary of this inspection

Are services caring?

- Staff and patients told us they felt patient dignity was compromised by having to request toilet roll and to be given a limited number of sheets. Staff and patients also told us they felt the use of safe wear on a daily basis on four of the seven patients was undignified. Paper underwear was not always available when a patient's normal clothing was removed and this meant that they felt their dignity had been compromised.
- Interactions and communication between staff and patients appeared to be limited on the ward. Staff and patients told us that staff often remained in the nurses office, which meant time was limited with patients and would not aid recovery. Staff and patients also told us that the number of different agency workers on the ward meant that they did not always have the opportunity to build therapeutic relationships. This could mean that recovery was not supported.
- Care plans evidenced encouragement of independence, active involvement and participation of patients and carers. Staff reviewed and adapted these when changes occurred. Patients were encouraged to write what worked well for them in the past to reduce their distress; however, staff did not always follow the care plans.

However:

- All families and carers we spoke with were positive about the involvement in the care and treatment. They also expressed that they were happy with the progress their loved ones had made since their admission.

Detailed findings from this inspection

Mental Health Act responsibilities

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

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

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

Long stay/rehabilitation mental health wards for working age adults

Safe	
Caring	

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

Safe and clean environment:

- Staff on ward B had good lines of sight to observe patients while they were on the ward. The nurses' station overlooked the patients lounge area. Convex mirrors and CCTV cameras were strategically placed to help staff monitor areas with blind spots.
- Staff carried out an audit of ligature anchor points in January 2017. They audited patient ensuite bedrooms and there were a number of identified risks, for example, the doors, curtains, and bedding. In the cases of individual patients who staff identified as having a continual risk, there were care plans written to help reduce those risks.
- The ward was a female unit and as such complied with same sex guidance.
- The clinic room was fully equipped and there was accessible resuscitation equipment and emergency equipment for staff to use to respond to an emergency. There was a checking system in place to regularly review the efficacy of the equipment. Pharmacy and staff were involved in reviewing medicines management and pharmacists attended the unit weekly to carry out audits.
- There was a seclusion room. Managers told us it was not used and we saw that it was not set up for use. The seclusion room was a ligature free room with shower and toilet facilities. There was a bed to sleep on. A secure TV and a digital clock to tell the time. Staff could observe patients in the seclusion room from an adjoining room that had sitting facilities. Staff could use a CCTV system to monitor patients. There were viewing windows and a two-way communication system.
- The ward environment was tidy and without clutter. The ward was clean in parts. However, there was noticeable dirt and dust on the floors in the corridor and two of the bedrooms we looked at. We looked in one patient ensuite bathroom, which was dirty. The toilet bowl and sink were stained and the floor was visibly dirty with dust and dirt.
- Staff had hand sanitisers that dispensed alcohol hand gels but when we checked they were empty. We asked the nurse in charge why the dispensers were empty and they said that patients sometimes tried to drink the gel. This meant that staff and patients did not always have access to hand sanitisation to aid infection control.
- We could see that equipment was maintained and there was portable appliance testing(PAT) stickers on electrical appliances and equipment which ensured they were safe to use.
- There were cleaners on the ward Monday to Friday. Staff were responsible for cleaning at the weekend. To reduce exposure to substances that were hazardous to health and to meet the requirements laid out by law, there was a Control of Substances Hazardous to Health (COSHH) cupboard to store cleaning products. Staff were COSHH trained.
- There were environmental risk assessments carried out and reviewed regularly. Lakeside View had a health and safety manager and onsite maintenance five days a week. There was regular maintenance work going on and the maintenance staff were always supervised by a clinical member of staff when carrying out work on the ward.
- All staff were allocated a personal alarm to keep in their possession and to use in the event of an emergency. These alarms were connected to a pinpoint alarm system. This meant that staff were directed to where the alarm had been activated and could respond promptly. In addition to the pinpoint alarm system, each room had an alarm button that could be used to alert staff to assist in an emergency.

Safe staffing:

- The ward staffing establishment was nine whole-time equivalents (WTE) qualified nursing staff and nine WTE

health care assistants. In addition, there was one WTE psychiatrist, one WTE psychologist, one WTE social worker, one WTE occupational therapist and a .2WTE technical instructor.

- There were no qualified WTE nurse vacancies and four WTE health care assistant vacancies. Bank staff then agency staff were back filling these vacancies. Lakeside View were undergoing a recruitment drive and these vacancies had been filled. Four of the health care assistants had been issued start dates.
- We looked at rotas over an eight week period. The rotas indicated regular use of bank and agency staff. A manager told us that the highest number of agency workers used was over the Christmas period. The duty rotas indicated that from week commencing 19 December to week ending 25 December 2016 there had been 34 agency workers covering 14 shifts. This did not include bank staff covering the same number of shifts during the same period. Two bank staff covered four nights shifts during the same period. There were similar patterns of bank and agency staff for the following three weeks.
- The ward had met its establishment levels for all shifts and the rotas indicated that bank and agency staff were booked during a period where there were no staff on annual leave. The manager told us this was to manage increased observations for patients.
- Sickness rates since October 2016 were low at around 2.41%. In October, sickness rates were2.18%, November 0.60%, and December 3.79%.
- The nurse in charge told us that staff turnover had been high and there had been five qualified nurses leave Lakeside View since it opened. There was no exit interview documentation contained within the staff files, we therefore were unclear about the reason for the high turnover of staff.
- The provider estimated the number and grade of staff needed for each shift based on the number of patients on the ward. The hospital director told us that they had employed staff sufficient for nine patients. Managers could adjust staffing to suit the changing needs of the patients and we saw this in the use of bank and agency staff.
- Managers tried where possible to ensure that bank staff were used in the first instance and that they used regular bank staff from within the organisation to ensure continuity. We also saw on rotas that where possible, agency staff were used who were familiar with the ward. We could see this was often difficult to achieve due to the high volume of staff and the high number of shifts cover during the December period.
- We did not see a staff in the communal areas at all times which would be good practice.
- Escorted leave did not appear to be cancelled for patients as a result of short staff.
- There was always qualified nurses on each shift to ensure physical interventions could be carried out.
- There was a consultant psychiatrist on site Monday to Friday to provide medical cover. There was an out of hours service. Patients experiencing physical emergencies would either attend their GP or emergency services.
- All staff had received mandatory training and had an induction at commencement of their employment. Staff files indicated new starters on the ward did not come with professional experience of working with the specialist patient group. New starters received a two-week induction, however the personality disorder element of the induction lasted one and half hours which may not sufficiently skill staff to work with personality disorder patients on an inpatient unit.
- We looked at supervision records for staff and sessions were not always available to staff on a regular basis. The content of the supervision sessions were not consistent and we did not see much reference to working with personality disorder. There were no staff support sessions as is indicated in The National Institute for Health and Care Excellence guidance: Personality Disorders for staff working with this often complex patient group.

Assessing and managing risk to patients and staff:

- There was a seclusion room but it was not set up for use and staff told us the seclusion room had not been used. There was a policy for seclusion and longer-term segregation dated December 2015. There were no recorded incidents relating to long-term segregation. Staff told us they did not use segregation.

Long stay/rehabilitation mental health wards for working age adults

- Staff were trained to use therapeutic management of violence and aggression. This meant that they were trained to use de-escalation techniques before progressing to other techniques, for example, restraint. Patients and staff told us that there were high levels of restraint used. We saw this evidenced in the number of restraints recorded.
- We looked at records relating to restraint for the period of October 2016 to 13 January 2017. There were no incidences of restraint in October. There were 11 restraints carried out on three patients in November. Staff used restraint 81 times in December for four patients. One of those restraints was prone restraint. Prone restraint means physically holding a patient face down. This can result in dangerous compression of the chest and airways and put the person being restrained at risk.
- Staff used rapid tranquilisation intra muscularly 28 times in December following restraint. Rapid tranquilisation was when patients were prescribed and administered medications to help with extreme episodes of agitation and anxiety. There were 34 incidences of restraint from 1 January until 13 January on five patients. Two of those restraints were prone restraint and rapid tranquilisation was used on two occasions.
- We looked at five care and treatment records. There were risk assessments for each patient in the care records prior to admission and on admission at the earliest opportunity.
- There were regular reviews of risk and each patient's risk was reviewed following incidents. The multidisciplinary handover meetings monitored these risks daily. Staff documented these meetings and records demonstrated assessment of risk.
- Qualified staff comprehensively assessed each patient for suitability for the service. There was an example of a decision to refer an inappropriate patient from Lakeside View to a low secure service. This was based on a comprehensive risk assessment and detailed consideration of how the risks identified could be better managed in a low secure service.
- There were no informal patients at Lakeside View. All patients were detained under the Mental Health Act.
- There were policies and procedures for use of observation. We saw this indicated in care plans, patient care records and observed one to one observations taking place on the ward at Lakeside View. Observations were primarily to minimise risk of the potential to use ligatures.
- There was a process of random searches that took place and we observed this being carried out. We noted that the search began openly in the reception area of the unit, but was then taken in to another room to be completed. Staff did not always fully complete the records relating to searches. For example, one record we looked at did not provide a description of the body search, which could limit how searches were audited.
- There were a number of ligature points and risks identified on the audit of ligature anchor points. Staff completed this audit in January 2017. The bedrooms, all with ensuite were audited and there were a number of identified risks, for example, the doors, curtains, and bedding. In the cases of individual patients who were identified as having a continual risk, there were care plans written to help reduce those risks.
- Patients with identified risks associated with self-harm were risk assessed and care planned to reduce the identified risks. However, staff did not complete specific care plans, in line with local protocols for the use of safe wear or safe bedding. Safe wear clothing and safe bedding are made of fabric that is difficult to rip. The consultant wrote up care plans following our initial inspection. Staff had not documented regular reviews for the restrictive practice of using safe wear and safe bedding.
- One patient told us they were worried about the nurses station being regularly left unlocked and patients accessing ligature cutters and a screwdriver which was kept in there. The ligature cutters were kept near the entrance to the nurses station and could be easily accessed by anyone. The nurses station had been left unlocked during our inspection. We told the nurse in charge. The nurse in charge locked the door and reminded staff to ensure it was locked. At our second inspection we saw that once again the door was left unlocked. This meant there was a continued risk to patients and staff.

- Staff were directed to use other calming techniques before considering rapid tranquilisation. The provider had a rapid tranquilisation policy, which did not incorporate the latest NICE guidelines published May 2015.
- Arrangements were in place to provide guidance to medical and nursing staff for this treatment. This included detailed guidance around which medication was to be given and in which order. This was annotated on the prescription charts for each patient and within each patients detailed care plan. It included time intervals to be taken between trying different medicines, to allow for a clinical response.
- From 16 December 2016 to 17 January 2017, on twelve occasions, three patients were administered two medicines at the same time intra-muscularly (IM) for managing aggression. Staff had not detailed this well in the patients individual care plans and did not comply with the written guidance documented within the care plans.
- Staff had administered simultaneous injections of an antipsychotic and benzodiazepine on three occasions to one patient. They may then have had an increased risk of experiencing excessive sedation and cardiorespiratory depression. We saw that patients appeared sedated when we inspected. Four patients were either asleep or lying on the sofas in the lounge area.
- A second patient, who had a history of seizures, had refused medicine used to prevent seizures on most days, since 24 December 2016. They had been administered a simultaneous combination of an antipsychotic and anti-histamine IM injection on six occasions. Anti-psychotics should be used with caution in patients who have a history of seizure disorder or have conditions associated with seizures.
- The provider trained staff in safeguarding and staff knew how to make a safeguarding alert and did this when appropriate. There were examples of when staff made safeguarding alerts of joint working with safeguarding colleagues. There were discussions in handovers and written documentation in patient records highlighting safeguarding management action points. The service had a safeguarding lead to support patients and staff with safeguarding concerns.
- Patients had access to a visitors room off the ward where they could see their friends and families. Visitors were care planned and there were safe procedures for visitors, including children that visited the ward.

Track record on safety:

- There had been no recorded serious incidents since Lakeside View were open for admissions their first patients in August 2016. NHS England define serious Incidents as adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.
- Lakeside View had a health and safety manager to oversee the potential for environmental risks and support staff in managing safety issues.

Reporting incidents and learning from when things go wrong:

- Staff knew how to report incidents. There was a good reporting system and there were a high number of incidents reported. Managers and staff from the multidisciplinary team could use the information from their incident reporting system to look at themes from incidents.
- The number of incidents had increased by nearly 100% from October to December 2016. We looked at incident reports for the ward for October, where there were a reported 11 incidences of self-harm. For November, there were 25 incidences of self-harm and for December, there were 101 incidences of self-harm. From 1 January to 13 January, there had been 37 recorded incidences of self-harm. The consultant, nurse in charge and hospital director told us that there had been a significant rise due to anxieties that might be expected around the festive period.
- Staff who attended the multi-disciplinary team meetings told us that they discussed incidents at morning meetings as a multidisciplinary team. The psychologist told us they carried out a brief review of incidents in December 2017. We did not identify any particular learning from the review. We looked through 33 incident reports and 13 daily handover minutes. Each

daily handover reviewed indicated at least one patient on staff assault. Staff in attendance had not referenced in the minutes how these would be managed and prevented in future.

- Staff told us that they recorded discussions about patient incidents in patient notes. Staff permanently employed at Lakeside View could access this information using a secure patient record system. There were regular references to learning from incidents in patient care notes. Agency staff could not access this information. This could mean they did not always have the most up to date and relevant information to keep patients and others safe.
- There were changes made to the environment following some incidents. For example, one patient had their door removed to prevent them from using the door to self-harm. Four of the seven patients had all their bedding and personal belongings removed to avoid self-harm. Staff kept the remote control in the nurses station to prevent patients from swallowing the batteries as a form of self-harm.
- There were a high number of patient on staff incidents but we saw no specific support mechanisms for staff and patients alike to help improve conditions. Two staff members told us they had not received a debrief following patient on staff assaults or learning from incidents.

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

Kindness, dignity, respect and support:

- We observed on the first day of our inspection that there were very limited interactions between staff and patients. We saw no interactions or communication between staff and patients while they were sitting in the lounge area. There were three patients asleep on the sofas in the lounge area. Staff did not interact with them.
- One staff member told us that permanent staff were often in the office which meant they did not spend time with patients. Two staff members and all patients interviewed said there were too many agency staff. This often meant interactions with patients were poor as a result. This could mean that patients might not feel supported in their recovery.
- Staff took patients to the 'quiet room' if they were distressed and required time away from the main ward area. This room was at the entrance to the ward and had a large viewing window without privacy screening. Anyone on the ward would have a full view of patients in this room. We saw that patients were taken to this room when they were distressed. This meant that patients did not have their dignity respected when they were distressed.
- Some patients swallowed objects as a form of self-harm. Staff told us that toilet roll was viewed as an object that might be used to self-harm. As a result, there was no toilet roll in some of the ensuite bathrooms. Patients who had been risk assessed had to ask for toilet roll and were given a ripped off amount. This could compromise the patients' dignity.
- The multi-disciplinary team assessed four of the seven patients as appropriate to wear special tear-proof clothing. A multidisciplinary meeting took place and each patient was individually risk assessed before this decision was taken. Staff deemed these patients to be at risk of shredding clothing to be used to self-harm or attempt suicide. These patients would also have to wear paper underwear. There were occasions when the ward had run out of paper underwear and patients would have to go without. One patient told us they were embarrassed by this. One patient would not speak to us because they felt humiliated by the safe wear clothing they had to wear.
- Four patients were sleeping on plastic mattresses and pillow cases. Their bedding had been risk assessed, removed and replaced with safe bedding to prevent it being used to ligature. Patients told us it was uncomfortable and undignified.

The involvement of people in the care they receive:

- The nurse in charge told us that all patients were orientated on to the ward on admission. They told us that patients were given a named nurse, associate nurse, and a key worker at that time. The nurse in charge told us that all patients were involved in their

care. One patient told us they did not know who their named nurse was. They told us they were not offered a copy of their care plan; however, the remainder of the patients spoken with did.

- One patient told us that staff did not wear names badges and it was difficult to know who they were. This was particularly evident when there were agency workers on duty.
- There was a whiteboard in the patient corridor to indicate which staff were on shift. The whiteboard in the patient corridor was blank. This meant that patients and staff could not see at a glance who was on duty at any time.
- Care plans we looked at were well-written and evidenced active involvement and participation of patients and where appropriate carers. There were regular multidisciplinary reviews and care plans were adapted to take in to account dynamic changes. There was evidence of encouragement of independence recorded in care plans and confirmed by a discussion with a patient. However, staff working directly with patients did not always use the care plans to support patient needs.
- The nurse in charge told us that all patients had access to an Independent Mental Health Advocate (IMHA). An IMHA is an independent advocate trained to work within the framework of the Mental Health Act 1983. They supported people to understand their rights under the Act and participate in decisions about their care and treatment. One patient told us that they did have access to advocacy. One member of staff did not know what an IMHA was.
- All families and carers we spoke with were positive about the involvement in the care and treatment of their loved ones. They also expressed that they were happy with the progress their loved ones had made since their admission.
- There were weekly community meetings for all patients to attend. One patient told us that they did not feel that it was a place to bring up issues. Another patient told us they knew how to complain and that they felt listened to.
- We saw no evidence of patient involvement in the development of the service. For example, there was on-going recruitment and patients were not involved in recruitment processes.
- Where appropriate, patients were encouraged to make advance statements in their care plans about what worked well for them in the past. One patient we spoke with told us that they had recorded in their care plan what worked well for them when they were distressed but staff had not followed those instructions. The patient told us this led to unnecessary distress.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The rapid tranquilisation policy must incorporate the latest NICE guidelines.
- Staff administering medicines must comply with NICE guidance and the written guidance documented within the care plans by the prescriber.

Action the provider SHOULD take to improve

- Staff should have access to hand sanitisers to prevent the spread of infections and aid infection control.
- Patient areas, including bedrooms and bathrooms should be kept clean. Standards of cleanliness should be maintained.
- The provider should find alternative ways to ensure patients are comfortable and treated with dignity when sleeping if they have removed all of the patients bedding.
- Patients should be afforded privacy, dignity, and respect if they use the 'quiet room' as a means to deescalate difficult emotions. People on the ward should not be able to observe patients when using the quiet room.
- Staff should follow their local protocol relating to the use of strong wear. For example, they should ensure that the multi-disciplinary team reviews its use daily and it should be used for the least amount of time.
- The nurses office which is situated in the patients lounge area should be locked at all times to ensure patient and staff safety on the ward.
- Staff should have access to a debrief following all incidents and learning from those incidents should be shared.
- Staff should receive adequate personality disorder training to ensure they are suitably skilled to work with the specific patient group.
- Staff should have quality therapeutic one to one time with patients on a daily basis to support them in their recovery.
- Staff should have access to regular and consistent supervision sessions.
- Staff should have suitable support sessions to help them work effectively and safely in their role in working with personality disorders.
- Agency staff should have access to all patient information so that they always have the most up to date and relevant information to keep patients and others safe.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12** **Regulation 12 Safe care and treatment** • The rapid tranquilisation policy did not incorporate the latest NICE guidelines published May 2015. • From 16 December 2016 to 17 January 2017, on twelve occasions, three patients were administered two medicines at the same time intra-muscularly (IM) for managing aggression. This did not comply with the written guidance documented within the care plans. • NICE guidance specifies a single IM injection, with sufficient time left after the injection to allow for a clinical response followed by a further injection if appropriate. One patient was given simultaneous injections of an antipsychotic and benzodiazepine on three occasions. This could mean they had an increased risk of experiencing excessive sedation and cardiorespiratory depression. • A second patient with a history of seizures, had been administered a simultaneous IM injection combination of an antipsychotic and anti-histamine on six occasions. Anti-psychotics should be used with caution in patients who have a history of seizure disorder or have conditions associated with seizures. This was a breach of regulation 12 (1) (g)