Chesterholme

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
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 Chesterholme as requires improvement because;

- There were insufficient staff on duty to ensure patients were able to have dedicated one to one time with their named nurse. Staffing figures did not allow staff to respond to incidents and maintain the required observation levels for patients at all times. Staff were regularly injured as a result of incidents.
- Patients were not provided with the level of meaningful activity as described in the provider's policy each week. Staff who were observing patients did not make efforts to engage patients in activities.
- There was a failure to deal with specific risk issues like falls. Staff did not review and update risk assessments and risk management plans regularly. Agency staff were not familiar with the patients and this resulted in incorrect treatment.
- Incident forms were not completed correctly and there were often several incidents recorded on the same form. Statutory notifications were not always completed as required by the Health and Social Care Act. Senior staff were not always aware of what incidents required reporting.
- The internal teams did not work effectively and required the activity co-ordinator to pass information between the teams.
- Staff did not receive regular clinical supervisions in line with the provider's policy. Staff did not feel respected, valued and supported. Staff were fearful of reporting concerns and incidents due to concerns about their jobs. Staff were not always provided with debriefs or support after incidents.

However;

- Permanent staff displayed a caring approach to patients and encouraged them to participate in activities outside the service.
- Staff participated in an annual audit schedule to ensure the safety and quality of the service provision.
- Access to the service was well managed and there were always beds available when patients returned from leave.
- The service was clean and tidy with good furnishings.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Requires improvement	

Summary of findings

Contents

Requires improvement

Chesterholme

Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Chesterholme

Chesterholme is an independent hospital located in Hexham, which provides care and treatment for up to 26 patients with a diagnosed learning disability or autism. Chesterholme is part of the Danshell Group. The service has been registered with the CQC since September 2013.

The service has a registered manager who has been in post for just over a year. There was an accountable officer in post.

Chesterholme is a two-storey unit which provides accommodation for both male and female patients. Within the service there are separate units, one for two females and the other for a single male who required more intensive support.

A comprehensive inspection was carried out in August 2015 and a follow up inspection was carried out in August 2016.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, one CQC assistant inspector, one occupational therapist and one registered learning disability nurse.

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 families and carers.

During the inspection visit, the inspection team:

- Looked around the service at the environment and observed how staff were caring for patients.
- Spoke with five patients who were using the service.
- Spoke with the registered manager.
- Spoke with 12 staff members, including doctors, nurses, support workers, occupational therapist, speech and language therapist, activity co-ordinator and housekeeper.
- Received feedback from three care co-ordinators or commissioners.
- Spoke with two independent advocates.
- Observed one care programme approach meeting.
- Observed one multi-disciplinary meeting.
- Looked at four care and treatment records of patients.
- Looked at six staff files.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

Some of the people who used the service did not wish to speak with the inspection team. However, patients who did speak with us told us that permanent staff treated them well and they were happy in the service.

Carers we spoke with told us that they were happy with the service. Carers told us that staff were polite and courteous and they were given information about their friend or relatives care.

However, some patients and carers expressed concern about the number of agency staff that were used in the service.

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?

Requires improvement

We rated safe as requires improvement because;

- There were not enough staff on duty to meet the needs of all the patients. When incidents occurred, there were not enough staff to respond to incidents and maintain required observation levels for patients.
- There was a high level of agency use. Agency staff were not always familiar with the service and were not given an induction prior to starting work in the service. Patients and permanent staff members did not feel safe due to the number of agency staff on duty.
- Although there were risk assessments in place, they were not always updated after incidents or as part of a routine review. Risk management plans were also not regularly updated meaning patients were not protected from potential harm.
- Staff did not always follow policies and procedures for the use of observation. During our inspection, staff were witnessed ignoring observation levels when patients were supposed to be within arms-length. Staff were also seen leaving patients in order speak with other staff, use the toilet facilities or to assist other staff.
- Staff did not always report and record incidents as required. A review of incidents showed that staff recorded more than one incident on reporting forms and these were often completed by staff on the next shift, rather than by the person involved. Staff failed to notify CQC of incidents as required by the Health and Social Care Act.

However;

- The service was clean and tidy. Furnishings were in good condition and the service was regularly decorated to keep it clean and fresh.
- All staff had participated in mandatory training. Training levels were over 75% for all mandatory courses. Staff were monitored to ensure they kept up to date with required training.

Are services effective?

Requires improvement

We rated effective as requires improvement because;

- Staff did not receive regular clinical supervision in line with the provider's policy.

Summary of this inspection

- Staff did not always update care plans when necessary. Patients who had started new activities did not have new care plans in place.
- Care plans did not always show the service used best practice.
- The teams within the service did not work effectively together.

However;

- Staff supported patients to live healthier lives and to make positive lifestyle choices.
- Staff participated in clinical audit. There was an annual audit schedule in place which was used to ensure the safety and quality of the service provision.

Are services caring?

Good

We rated caring as good because;

- The majority of staff displayed a caring, respectful and considerate approach to patients. Staff provided patients with help and emotional support when needed and the majority engaged well with patients.
- Staff directed patients to other services like support groups, voluntary services, local clubs and government offices.
- Staff were aware of individual needs and preferences. Staff involved patients in care planning and this was recorded in care records.

However:

- Some staff did not interact with patients. Staff who carried out observations were supposed to try to engage them in conversation or meaningful activity but this was not being done by all staff.

Are services responsive?

Good

We rated responsive as good because;

- All patients had their own room with ensuite facilities. Patients were encouraged to personalise their rooms with things that were important to them.
- The service made adjustments for disabled people. Although none of the rooms had been adapted, the registered manager told us that adaptations could be made for disabled patients if needed.
- Patients were supported through discharge and transfer to other services.

However;

- Risk management plans were not regularly updated.

Summary of this inspection

Are services well-led?

Requires improvement 

We rated well-led as requires improvement because;

- Staff did not feel valued, respected and supported. Staff felt that they were not able to report concerns and incidents, as this would potentially result in them losing their jobs.
- Statutory notifications were not always submitted when required.
- Staff were not always debriefed or supported following incidents.
- Teams in the service did not work well together. Staff of all levels told us that members of the multi-disciplinary team to not speak to care staff about their roles. This meant that it was difficult to ensure information about patient care.

However;

- The provider was aware of their requirements in relation to equality and diversity.

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.

All staff working in the service were required to participate in training in the Mental Health Act.

Staff explained patients' rights under the Mental Health Act to them in a way they could understand. Care records showed when staff had explained patients' rights to them.

Staff stored copies of patients' detention papers and associated records correctly. Staff checked Section 17 leave forms before they escorted patients on leave. Old Section 17 forms had been scored through and moved to the hospital's holding file.

Informal patients were provided with a key fob which allowed them to come and go freely. The hospital displayed a sign to show patients who were informal could leave when they wanted.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff working in the service had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

The provider had a policy in place which related to the Mental Capacity Act and staff were able to gain easy access via the provider's intranet.

Care plans showed evidence of capacity assessments being carried out. However, one care plan showed a capacity assessment which had been completed for multiple decisions rather than one specific decision as described in the Act.

The provider made applications in relation to the Deprivation of Liberty Safeguards only when they were justified. All applications were monitored, recorded and stored properly.

Where patients lacked capacity, best interest decisions were made on their behalf and recorded in care records.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

Staff carried out regular assessments of the care environment. Environmental checks were carried out annually with the last being done on 7 September 2018. These checks included lifts, hazardous materials, lighting and fire. An environmental ligature assessment was carried out regularly.

Ward layout did not allow staff to observe all parts of the ward. The service was spread over two floors and there were a number of narrow corridors and blind spots. The service did not have closed circuit television installed, although risks were mitigated with the use of observations and risk management.

There were several potential ligature anchor points throughout the service. The service tried to mitigate the risk of ligature with the use of observations. There were no patients who were considered a ligature risk at the time of our inspection.

The ward complied with guidance on eliminating mixed sex accommodation. Patients in the service were not required to share bedrooms and all rooms had en-suite facilities. Male and female patients had access to their own lounges and bathing facilities.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff were provided with personal alarms which they carried throughout their shift. However, some staff told us that alarms could often go off accidentally due to being dropped or knocked and in some cases alarms had failed to activate when needed as the cords attached had snapped. This meant that staff were not protected from potential harm.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well maintained. The service was well decorated with décor that provided a low stimulus environment. Any repairs were noted in the maintenance book and were dealt with as soon as possible, usually within 24 hours of being reported, unless parts needed to be ordered.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. The service employed housekeeping staff to keep the service clean.

Staff adhered to infection control principles, including handwashing. Hand sanitiser dispensers were located on walls throughout the service and staff were witnessed washing their hands. Infection control audits were carried out regularly to ensure the service followed infection control principles.

Seclusion Room

The service did not have a seclusion room and patients were not secluded in any other area of the hospital.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. All the equipment in the clinic rooms was in date and had been recalibrated in line with the manufacturers recommendations.

Requires improvement

Wards for people with learning disabilities or autism

Safe staffing

Nursing staff

Between 1 August 2017 and 31 July 2018, the whole time equivalent staff employed at the service were;

Qualified nurses – 5

Nursing assistants – 20

There were no qualified nurse vacancies, although there were ten vacancies for nursing assistants.

The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in the 12-month period from 1 August 2017 to 31 July 2018 was 547. There were no shifts that had not been filled during this period.

In the 12-month period from 1 August 2017 to 31 July 2018 the service had a sickness rate of 2.1%.

Managers had calculated the number and grade of nurses and healthcare assistants required. However, the number of staff on shift was not always sufficient to ensure patients were given the support needed and that patients and staff were kept safe.

Staff rotas for the three months prior to our inspection, showed that the number of staff on duty was the same as the requirements for the same period.

The manager could adjust staffing levels daily to take account of the case mix. When necessary, the manager deployed agency and bank nursing staff to maintain safe staffing levels. However, staff rotas for the three months prior to our inspection showed that although bank and agency staff had been used, it was still not possible to support all patients in a safe and effective way.

Staffing levels did not always allow patients to have regular one-to-one time with their named nurse. Some of the patients we spoke with told us that although they had time scheduled for one-to-one time, this was not always possible as other patients required assistance and the nurse or support worker was often called away. Throughout our inspection we witnessed staff being interrupted when spending time with patients and saw this could be both distracting and upsetting to patients. Some staff were not able to return to what they had been doing for several minutes and this meant patients may have moved on to another activity or did not want to continue with what they had been doing before the interruption.

Staffing levels within the service often resulted in emergency alarms being activated. Where patients required enhanced observations, if a staff member was called away this left staff and patients vulnerable and resulted in staff having to use emergency alarms to ensure they had the correct level of support. We saw this happen on more than one occasion during our inspection.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Several of the patients were able to leave the hospital and take part in activities independently, which meant that staff shortages didn't have the same impact on activities.

There were not enough staff to carry out physical interventions (for example, observations and restraint) safely (and not all staff had been trained to do so). The service had a risk assessment in place to establish the number of staff who could work during each shift without having the appropriate physical intervention training. The risk assessment was reviewed on 12 November 2018 and at that time it was decided that there should be no more than two staff on day shifts and one on night shift, that had not been trained.

At the time of our inspection there were 13 patients, ten of whom were on enhanced observations. For example, on 13 November, one patient needed three care staff with them at all times, two patients required two care staff and seven required one member of staff with them. There were 15 care staff on duty on that day, with an additional nurse who was carrying out paperwork and a healthcare assistant who was brought in specifically to take one of the patients out for the day. This meant there were three staff to support the other patients and to assist other staff where required, including responding to alarms and covering breaks.

When agency and bank nursing staff were used, those staff did not receive a local induction and not all were familiar with the ward. Staff we spoke with told us that agency staff were often brought in at the last minute and had no knowledge of the service. Patients we spoke with told us that they didn't know a lot of the agency staff and they didn't like these staff caring for them because they didn't know them. The service manager told us that the hospital had started block booking agency staff to ensure this wasn't an ongoing problem. In addition, the service was planning to introduce an agency induction programme and meet and greet day to help staff and patients get to know them.

Requires improvement

Wards for people with learning disabilities or autism

The layout of the service meant that a qualified member of staff could not be present in all communal areas. However, we did find that there was a healthcare assistant in the majority of communal areas, when there was a patient present.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. Danshell employed one full-time doctor who worked across three different sites. The doctor was usually based at Chesterholme on Thursday and Friday. A locum doctor worked with the service on a part-time basis and shared the out of hours cover. The doctor told us he could be contacted via telephone every day and a doctor could attend the service within one hour if needed.

Mandatory training

Permanent staff had received and were up to date with appropriate mandatory training. Staff completed mandatory training in 17 different subjects. These included infection control, safeguarding children and adults, moving and handling and positive behavioural support training. The service was achieving the provider's compliance rate for all mandatory training subjects, which was 80%.

Assessing and managing risk to patients and staff

Assessment of patient risk

During our inspection we looked at the care records of four patients. Staff used a risk assessment tool to assess and record risks.

Staff did a risk assessment of every patient on admission but these were not regularly updated, including after an incident. Of the four care records we looked at we found all had a risk assessment in place but only one had been updated regularly. One risk assessment had been completed with a summary of risks but there were no details of how these could be mitigated.

Management of patient risk

Staff were not always aware of and did not always deal with specific risk issues, such as falls or seizures. Some of the patients in the service were at risk of falls but risk management plans were not always updated and did not give details of how risks could be mitigated. For example, one patient's falls risk management plan had not been updated since December 2017, even though the patient had suffered falls between that date and the time of our inspection.

Staff identified but did not always respond to changing risks to, or posed by, patients. Patient's risk assessments and risk management plans did not always identify new risks and where risks had been identified these were not always updated appropriately.

Staff did not always follow policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms. Staff in the service did not routinely search patients or their bedrooms, this was only done if there was a specific reason or cause for concern. However, we found that staff did not always follow the observation policy. Observations for patients were adjusted according to their individual needs and acuity but we found that sometimes patients who required one-to-one support, were left alone so that a staff member could request someone else take over. We also found that patients who were required to be within arms-length of staff members were allowed to move up to 100 feet from them. This meant that the patient or others in the service could be at risk of harm.

Staff adhered to best practice in implementing a smoke-free policy. Staff in the service were able to offer advice on smoking cessation and were able to provide nicotine replacement therapies if patients wanted to use these.

Informal patients could leave at will and knew that. Signs were displayed to show informal patients they were able to leave the hospital when they wanted to. Informal patients were also provided with key fobs which allowed them to open the external doors and access the outside areas.

Use of restrictive interventions

In the six-month period from 1 August 2017 to 31 January 2018, the service recorded 124 incidents of restraint which involved 12 separate patients.

The provider had a policy in place which reflected guidance issued by the National Institute of Health and Care Excellence. We asked the registered manager to give us information on the number of times rapid tranquilisation had been used in the 12-month period from 1 August 2017

to 31 July 2018, but this information was not provided. However, we were provided with two records, which showed that staff had carried out observations on these patients.

The service participated in the provider's restrictive interventions reduction programme. The service did not use seclusion or long-term segregation. We asked for comparison information to show if there had been a reduction in the use of restraint but this was not provided.

Staff used restraint only after de-escalation had failed and used correct techniques. All permanent care staff were provided with physical intervention training. Staff and patients we spoke with were able to give examples of the types of hold used as part of this training. During our inspection, we witnessed staff making attempts to de-escalate the situation prior to restraining anyone. Where restraint was required staff used correct techniques.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff were aware that restraint should be used as a last resort and for the shortest time possible.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. All staff in the service were required to complete safeguarding training for both adults and children. Notifications had been submitted to the local safeguarding authority when required.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with were aware of different types of abuse and were able to tell us how they could protect people from abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff were aware of the signs of abuse and made referrals to police, local safeguarding authorities and other agencies as required.

Staff followed safe procedures for children visiting the ward. The provider had a policy in place in relation to child visitors and staff were aware of this. Child visitors were not allowed into the ward area but were able to visit in an off-ward visitors room.

Staff access to essential information

The service used both paper and electronic records, although care plans were paper based with incident reporting being completed electronically.

Staff completed communication passports and positive behavioural support plans for all patients. Important information was included on a grab sheet which was used if patients left the hospital. For example, to go to a medical appointment. All patients had a meaningful activity care plan in place.

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. This included when patients moved between teams. Staff were able to view records relating to patients and changes were communicated during shift handovers. However, staff we spoke with told us that agency staff were not given time to get to know the patients and their individual needs prior to starting work. Patients we spoke with told us that some agency staff did not know them and this caused problems. When patients were transferred to other teams, the receiving team was provided with all relevant information prior to the transfer.

If staff were expected to record information in more than one system (paper or electronic), this did not cause them any difficulty in entering or accessing information. Staff who needed to record information were able to gain access to electronic and paper systems and were able to record updates as needed.

Medicines management

Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, used of covert medication) and did it in line with national guidance. Staff had received training in medicines management and ensured that the were handled and disposed of safely.

Staff reviewed the effects of medication on patients' physical health regularly and in line with guidance from the National Institute for Health and Care Excellence, especially when the patient was prescribed a high dose of

antipsychotic medication. Staff used relevant physical health monitoring to ensure that patients were not affected my medications. Physical health monitoring was recorded in care plans.

Track record on safety

The provider reported 12 serious incidents between 1 August 2017 and 31 July 2018. These included, five incidents of actual or alleged abuse of a patient by a third party, two apparent/actual or suspected incidents of self-harm, four actual or attempts to abscond and one case of disruptive/aggressive or violent behaviour.

Reporting incidents and learning from when things go wrong

Not all staff knew what notifications to report and how to report them We spoke with the registered manager about incidents and which would be reported to CQC. We found that the manager was not aware of all the reporting requirements.

Staff had not reported all incidents that they should report. We spoke with staff and looked at the incidents reported to CQC in the six months prior to our inspection and found, reports had not been submitted for all incidents. For example, any incidents which result in a damage to a bone should be reported. However, the provider was not aware of this requirement and a notification had not been submitted when needed.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation when things went wrong. Staff were able to tell us what the duty of candour was and said they felt it was important to be open and honest.

Staff received feedback from investigation of incidents, both internal and external to the service. The provider shared learning from incidents throughout their services and this helped to ensure that lessons learned and practice were the same throughout their services.

Staff met to discuss feedback. Lessons learned and feedback from incidents was shared with staff at team meetings, and handovers.

There was evidence that changes had been made as a result of feedback. The hospital manager provided us with details of changes that had been implemented in order to make the service safer. These included, introducing coping strategy boxes to provide accessible and soothing strategies for patients, introduced reflective practice sessions and introduced positive behaviour support and communication grab sheets to make information about patients available to staff quickly.

Staff were not always debriefed and supported after a serious incident. Staff we spoke with told us that they were not always able to have time out after incidents due to staffing levels. This impacted on their ability to have a debrief and obtain support. We saw evidence of multiple incidents happening in short periods of time which meant staff were not able to have time out in between incidents.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

During our inspection we looked at the care records of four patients, three of which did not demonstrate good practice in the areas reported on below (for example, holistic, evidence of physical assessment and so on). All of the records we looked at contained evidence of physical health assessments being completed, although one did not show further reviews had been carried out until two years later. There was no reason recorded for this.

Staff did not always update care plans when necessary. Care records we looked at did not contain regular updates to patients' care needs. Some of the patients had been in the service for more than two years but when we reviewed their care records we found they still had the same care plans in place. For example, one patient who self-harmed did not have a care plan in place to manage this behaviour or to tell staff how they should deal with it if they witnessed the patient self-harming.

Care plans were personalised, holistic and recovery oriented. Care records showed staff had considered individual needs and had ensured that they included all areas of people's lives.

Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. Of the records we reviewed, we found they all contained evidence of mental health assessments being carried out in a timely manner.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. These included medication and psychological therapies and, training and work opportunities intended to help patients acquire living skills. Several patients in the service had jobs and voluntary work opportunities.

Staff ensured that patients had access to physical healthcare, including access to specialists when needed. Hospital patients were supported to attend appointments relating to their physical health. This included appointments with people like, dentists, opticians, dieticians and podiatrists as well as more specialised roles like neurologists.

Staff supported patients to live healthier lives – for example, through participation in smoking cessation scheme, health eating advice, cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse. Patients' care records showed evidence that staff supported them to live access screening services and gain treatment and advice on healthier living.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Some of the patients at the hospital suffered from dysphasia, this is a problem which can sometimes cause difficulty with swallowing. The service had a speech and language therapist linked to the hospital who carried out assessments to see if patients needed specially prepared food.

Staff used recognised rating scales to assess and record severity and outcomes. Staff used different outcome scales to monitor patient outcomes. These included the Model of Human Occupation Screening Tool and the Health of the Nation Outcome Scales.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. There was an annual audit schedule in place which was used to ensure the safe care of patients and quality of the service. Audits included, medications management, infection control, Mental Health act and safeguarding. Action plans were produced following audits to ensure any errors were corrected.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients. As well as doctors and nurses the service had an occupational therapist, clinical psychologist and a speech and language therapist. In addition, external support was available from social workers, dieticians and pharmacist.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Permanent staff had been trained to ensure they had the relevant knowledge and skills required to work in the service. However, there was a high usage of agency staff and not all of these had received training in physical interventions and the majority had not received a company induction, although this was due to be rolled out soon after our inspection. A risk assessment had been carried out to see if it was safe to operate with staff that weren't trained in physical interventions. This meant that there were no more than two members allowed on any shift, who had not received the training.

Managers provided new staff with appropriate induction (using the care certificate standards as the benchmark for healthcare assistant). People who were employed as permanent staff were provided with all the necessary training including a company induction. However, agency workers were not given any training by the provider and did not receive an induction. Although checks were carried out to ensure agency workers were given training, this was not the same as the training permanent staff got and may not have been as effective.

Managers provided staff with supervision (meetings to discuss case management, to reflect and learn from practice, and for personal support and professional development) and appraisal of their work performance. Permanent staff were required to participate in six supervision meetings in a 12-month period and have two appraisal meetings during the same period. Agency staff received supervision from the employment service, by someone who did not see them working.

The percentage of staff had had an appraisal in the last 12 months was 61%. The appraisal figure was low as some staff had not been employed for 12 months or were off work

The percentage of staff that received regular supervision was 65% this information was given to us by the provider within the provider information return.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Permanent staff were able to request training that would enhance their performance within the role they carried out. Approval for training was via the provider's parent company.

Managers ensured that staff received the necessary specialist training for their roles. Where required, staff were provided with specialist training such as, venepuncture, epilepsy and falls.

Managers dealt with poor staff performance promptly and effectively. Any concerns in relation to performance were addressed with the individual during appraisal and supervision. If needed they were also discussed outside of these times. Where staff had been found to be performing below the required standard or inappropriately, action was taken in accordance with the provider's policy.

Managers did not recruit any volunteers to work in the service.

Multi-disciplinary and inter-agency team work

Staff held regular, although not always effective, multidisciplinary meetings. Weekly meetings were held in the service but information shared was not always recorded fully or fed back to support staff. This meant there was often a discrepancy in the work being carried out and recommended changes. The manager of the service had recognised these concerns and had implemented a new document which was used for these meetings. This allowed doctors to fully document requirements in relation to patients' care and treatment and these were used to plan care. When we inspected the service, the new system had been in operation for one month but was showing how it could effect change.

The ward teams did not have effective working relationships with other teams within the organisation. All the staff we spoke with told us there was no real relationship between the support staff and other staff. We were told that doctors, occupational therapists, psychologists and other professionals passed information to one member of staff, who in turn told support staff. Staff told us this person was 'the bridge' between teams. This meant the service could not guarantee that information was passed on effectively if this person was not at work.

The ward teams had effective working relationships with teams outside the organisation. Staff within the multi-disciplinary team appeared to have effective relationships with outside agencies. However, representatives from one agency told us they did not feel they had enough interaction with the service. We spoke with representatives from other agencies, who told us they worked well with the service and felt that staff were polite and courteous.

Adherence to the MHA and the MHA Code of Practice

Permanent staff working in the service were required to participate in training relating to the Mental Health Act. Information from the provider showed that 88% of staff had received this training.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its code of practice. Staff knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance. The provider's Mental Health Act policy was regularly reviewed and updated as required.

Staff had easy access to local Mental Health Act policies and procedures and to the code of practice. Staff were able to access the provider's policies via the service intranet. All permanent staff were able to access this, while agency staff would be able to access a hard copy of the Act.

Patients had easy access to information about independent mental health advocacy. The service had notice boards throughout the hospital and this showed information relating to advocacy services. The service used two main advocacy services and representatives from each visited the hospital weekly.

Staff explained to patients their rights under the Mental Health Act in a way they could understand, repeated it as

required and recorded that they had done it. Patient care records showed staff had explained patients' rights regularly. There was an easy read version of patients' rights available for those who required it.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Patients were able to have regular Section 17 leave. Staff supported patients who wanted help and escorted other patients who were unable to leave the hospital alone.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them. Staff checked Section 17 leave forms before they escorted patients on leave. Old Section 17 forms had been scored through and moved to the hospital's holding file.

The service displayed a notice to tell informal patients that they could leave the hospital freely. Informal patients in the service were provided with access fobs which allowed them to come and go when they wished.

Care plans clearly detailed information about aftercare services and these were arranged prior to patients being discharged.

Staff did annual audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. The last audit was carried out in May 2018 and the findings were fed back to the service with appropriate actions to be completed. Actions were recorded as completed within timescales and additional actions to ensure compliance were recorded on the action log.

Good practice in applying the MCA

Information from the provider showed that 88% of staff had received training in the Mental Capacity Act.

Staff had a good understanding of the Mental Capacity Act and the five statutory principles. Although some staff were not able to tell us the statutory principles, they were able to tell us what they meant. Care plans showed evidence of capacity assessments being carried out. However, one care plan showed a capacity assessment which had been completed for multiple decisions rather than one specific decision as described in the Act.

There were two deprivation of liberty safeguards applications made in the six months from 21 February 2018 to 21 August 2018.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Permanent staff were able to access the provider's policies via the intranet and agency staff were able to access hard copies of the policy as required.

Staff knew where to get advice from regarding the Mental Capacity Act, including deprivation of liberty safeguards. Staff told us they would speak with the Mental Health Act administrator if they had any queries regarding the Mental Capacity Act.

Staff carried out assessments to determine if patients had the capacity to make decisions about their care. However, care records did not include details of assistance given to patients to help them make decisions, although communications passports were in place.

For patients who might have impaired mental capacity, staff assess and recorded capacity to consent appropriately. However, one care plan we reviewed showed that multiple decisions had been included in one capacity assessment. This meant the patient had been assumed to lack capacity in all areas although they may have had the ability to make some decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Best interest decisions were recorded in care plans with the reasoning behind the decision clearly noted.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies. Deprivation of liberty applications were not made without justification. All applications were recorded and stored appropriately.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it. Monitoring of compliance was conducted as part of the annual audit. Random checks were carried out and any concerns were documented and used to produce an action plan for the hospital. The last audit was carried out in May 2018.

Requires improvement

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

Staff attitudes and behaviours when interacting with patients showed that the majority were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. However, some staff failed to engage patients in activities and were seen sitting silently with minimal interaction. When we did see these staff supporting patients, they were polite and respectful toward them.

Staff supported patients to understand and manage their care, treatment or condition. Staff spoke with patients about their health and spent time with them individually to discuss any support or information they needed.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Patients were directed and supported to access things like, support groups, voluntary services, local clubs and interests and government offices to ensure they were able to gain help and advice and become part of the local community.

Patients said staff treated them well and behaved appropriately towards them. However, some patients told us that it they did not know some agency staff and this made it difficult for them to trust the staff and to feel comfortable. The hospital manager told us this was being rectified by having the same agency staff working in the service and also be allowing them to participate in a meet and greet day prior to starting work there.

Permanent staff understood the individual needs of patients, including their personal, cultural, social and religious needs, but agency staff did not know patients of their individual needs as they were not given the opportunity to get to know them or read their care records. Permanent staff were aware of individual needs and preferences and this was evident in the way they supported people. For example, staff knew that some patients had routines they looked to follow.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Concerns in relation to the treatment of patients had been noted and investigated. Where necessary, reports had been made to relevant external agencies.

Staff maintained the confidentiality of information about patients. There had been no recorded incidents of breach of confidentiality over the 12 months prior to our inspection. Staff were aware of their responsibilities in relation to patient confidentiality and why it was important.

The involvement of people in the care they receive

Involvement of patients

Staff used the admission process to inform and orient patients to the service. Patients were provided with a welcome booklet which gave them information on the service and the surrounding area.

Staff involved patients in care planning and risk assessment. Care plans showed that patients had been involved in discussions about their care and risks associated with their behaviour and health conditions.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. The service had access to various communication methods and staff were able to use these to help them explain things to patients in a way they understood. Methods included easy read, Makaton and talking mats. Staff were also able to access signers and interpreters if they were required.

Staff enabled patients to give feedback on the service they received. Patients were asked for their feedback through surveys and comments boxes. The service had 'you said, we did' boards to show what affect feedback had had.

We did not see any evidence of advance decisions in care plans, or of staff supporting patients to make a decision about these.

Staff ensured that patients could access advocacy. Two local advocacy services visited the hospital regularly. Patients were able to make appointments to speak with advocates and to have them present during meetings about their care.

Involvement of family and carers

Requires improvement

Wards for people with learning disabilities or autism

Staff informed and involved families and carers appropriately and provided them with support when needed. Families were provided with information about patients' care and were involved in decisions about the treatment.

Staff enabled families and carers to give feedback on the service they received. The hospital encouraged families and carers to give feedback, via comments boxes, surveys and meetings as well as ensuring they were able to speak directly with a member of staff if they wanted to.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Bed management

The average bed occupancy for the period 1 February 2018 to 31 July 2018 was 79.8%

There were no out-of-area placements attributed to this service in the last 12 months.

Beds were available when needed for patients living in the 'catchment area'. During the 12 months prior to our inspection, there were no patients within the catchment area, who met the admission criteria that were not placed in the service.

There was always a bed available when patients returned from leave. During the 12 months prior to our inspection there was never a time when patients were not able to return to the service, due to insufficient beds.

During the 12 months prior to our inspection, there was only one occasion where patients were moved for a reason which was not for a clinical reason. This was due to the admission of another patient who had specific needs, which meant they needed to be cared for in a specific area. This had resulted in two patients being unsettled for a short period of time.

When patients were moved or discharged, this happened at an appropriate time of day. All discharges were planned in advance to ensure that patients moved during the day. There had been no moves from the hospital at unsociable hours in the 12 months prior to our inspection.

Discharge and transfers of care

Discharge was never delayed for other than clinical reasons. In the 12 months prior to our inspection there were no delayed discharges from the service.

Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. Patients who were being discharged were supported through the process and staff spent time with them planning and discussing each step.

Staff supported patients during referral and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. Patients were supported to attend hospital appointments and routine screening if they wanted or needed assistance. Where patients needed more urgent care, due to illness or injury, staff always accompanied them to ensure they felt safe and understood what was happening.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. All patients had their own room with ensuite facilities.

Patients could personalise bedrooms. Patients had decorated their rooms with pictures and photos, duvets and personal items.

Patients had somewhere secure to store their possessions. All patients had locks on bedroom doors and a locker in which to store their possessions. Some patients had keys to their room and locker. Individual assessments had been carried out to determine whether patients were able to keep their keys.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. The service had seven lounges, one of which was female only, an art room, a classroom, an activities of daily living kitchen and a garden area. At the time of our inspection, one of the dining areas was being used for daily exercise and the art room

contained a pool table which was being used as a table. The classroom was also used for playing on games consoles. There were several empty bedrooms which were unused and the manager had requested a change of use for these rooms.

There was a quiet area where patients could meet visitors. The service had a visitor's room which could be used for children's visits and patients were also able to take visitors into the lounge or dining areas.

Patients could make a phone call in private. Patients were able to keep and use their own mobile telephone unless an individual risk assessment established that it wasn't safe.

Patients had access to outside space. The service had an enclosed garden which patients were able to access at all times.

The food was of a good quality. The service had a four-week rolling menu that gave patients choices at meal times. If patients did not want food that was offered they were able to obtain alternatives if requested.

Patients were able to access hot and cold drinks and snacks 24 hours a day. However, we did not see any risk assessments to establish if it was safe for patients to make their own drinks and we were unsure if patients were able to make hot drinks and snacks without restriction.

Patients engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. Several patients from the service had jobs in the local area and staff had created jobs for patients who weren't ready to work outside the service. The service had a teacher who visited twice a week and helped patients with educational skills.

Staff supported patients to maintain contact with their families and carers. Where possible, staff encouraged patients to visit families and carers and to maintain a relationship with them. Families were encouraged to visit the service and to participate in special events.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and the wider community. Patients told us they had made friends through work and leisure activities. Patients spoke positively about their relationships they had with staff and other patients who used the service.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. The service was accessible to disabled people and there was a lift available to ensure they could access all areas. However, none of the bedrooms or bathrooms had been adapted. The registered manager told us that changes could be made to the service in order to meet the specific needs of individuals.

Staff ensured that patients could obtain information on treatments, local service, patients' rights, how to complain and other subjects. The information provided was in a form accessible to the particular patient group. The service had a number of easy-read booklets on display which gave information on different subjects.

Staff made information leaflets available in languages spoken by patients. The staff had access to the provider's library of information available in different languages.

Managers ensured that staff and patients had easy access to interpreters and/or signers. Staff were able to request interpreters and signers to speak with patients and their family or carers who might require them.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. At the time of our inspection there were no patients with these food requirements. However, we were told that the service would be able to cater for patients who had specific requirements.

Staff ensured that patients had access to appropriate spiritual support. The service did not have a multi-faith room, although patients with the appropriate Section 17 leave were able to attend local religious services if they wanted to. Patients who did not have leave could request access to the representative of a particular faith and this would be arranged.

Listening to and learning from concerns and complaints

In the 12 months prior to our inspection, the service received two complaints and 12 compliments. Of the complaints received, none of them was upheld and none of them was referred to the ombudsman.

Requires improvement

Wards for people with learning disabilities or autism

Patients knew how to complain or raise concerns. Patients we spoke with told us they told the staff if they wanted to complain. Some told us they would also tell family members, who would in turn make a complaint on their behalf.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients told us that they could speak to staff if they were wanted to complain about other patients. We were aware that patients had raised concerns regarding the use of agency staff. Patients we spoke with told us they had not been worried about complaining.

Staff knew how to handle complaints appropriately. Both the complaints that had been received had been dealt with in line with the provider's complaints policy and procedures.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. Investigations had been carried out into complaints and actions had been put in place from the findings. We saw evidence of these changes having taken place during our inspection.

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

Requires improvement

Leadership, morale and staff engagement

Leaders had the skills, knowledge and experience to perform their roles. The registered manager had worked for the provider as a registered learning disabilities nurse. This meant they were aware of the service and the provider's policies and procedures. The manager told us they felt supported in their role and if needed would be able to access additional support.

Leaders were visible in the service, although some staff felt they were not approachable. Patients told us they would speak with staff if they had any complaints or concerns.

Leadership development opportunities were available, including opportunities for staff below team manager level. The registered manager told us that they had participated in a leadership course and that staff could apply to do the course.

Vision and values

The provider's vision was, 'To make a positive difference to people and their families by delivering personalised health and social care that helps them to achieve the things they want out of life.

The values were;

- Person Centred - We will put the person and their family at the centre of all our work and listen and act on what they tell us
- Rights based - We will respect and promote the human, legal and civil rights of the individuals who use our services within our organisation and wider society
- High Quality - We will provide care and support that is safe, evidence based and outcome focused
- Appreciative - We will work with people in a manner that is hopeful and encouraging, using positive and strength based approaches
- Empowering - We will support people in a manner that is progressive and enables them to exercise choice and control
- Transforming - We will work with our partners to create pathways that enable people to grow and achieve their goals.

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

Staff had the opportunity to contribute to discussions about the strategy for their service. Senior manager told us they had recently held an event to speak with staff about the service and had given the opportunity to raise any concerns. Staff we spoke with told us that they did not feel able to raise concerns as they did not feel they would be well received.

Staff could explain how they were working to deliver high quality care within the budgets available. Staff we spoke with were clear about how their work impacted on patients and told us that they wanted to deliver the best care. However, they also told us that they were not able to deliver the quality of care they wanted due to staffing levels.

Culture

Staff did not feel respected, supported and valued. Staff we spoke with told us they did not feel they received an appropriate level of support and did not feel valued by senior managers.

Requires improvement

Wards for people with learning disabilities or autism

Staff did not feel able to raise concerns without fear of retribution. Some of the staff we spoke with told us they were scared to tell managers about things because they might lose their jobs, some staff did not want to speak to us because managers might find out what had been discussed.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian, although they did not feel they could safely use this. Prior to our inspection we received information through the whistle-blowing process and followed up on the information provided. The person who had sent the information told us they feared they would lose their job if anyone found out.

Managers dealt with poor staff performance when needed. Staff followed the provider's policy when dealing with staff performance issues. We saw evidence of this through looking at staff files and by being told directly of agency staff being prevented from working in the service.

Teams in the service did not work together. There was a disconnect between the care team and members of the multi-disciplinary team. One member of staff who was employed as an activities co-ordinator worked with both teams to try and ensure that information was passed between teams where needed.

Staff appraisals contained information about career development and how it could be supported. Appraisal forms were reviewed during the inspection and showed that staff were given the opportunity to discuss their career and how they would like to progress. Staff were able to request training that would be valuable to their career.

Staff reported that the provider promoted equality and diversity in its day to day work. Staff reported that they received training in equality and diversity. The registered manager was clear about how the service was able to promote equality and diversity and was able to give an example of this. We reviewed the care record of one patient which gave details on how the hospital was meeting equality and diversity requirements.

The sickness and absence figures for the service were 2.1% for the 12 months prior to our inspection.

Staff had access to support for their own physical and emotional health needs through the provider's employee assistance programme.

The provider recognised staff success within the service. The provider had annual awards ceremonies for staff that had been nominated. Staff were nominated by other employees, managers and other visitors to the service.

Good governance

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff were able to tell us about changes that had been made following incidents and complaints. This included changing how visitors accessed the service and changing the door on one room following an incident.

Staff undertook or participated in local clinical audits. Clinical audits were carried out throughout the service and action plans were created following their completion. Audits were used to ensure the quality of the service delivery.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. Staff worked with other teams to ensure that patients were given the best care possible. This included arranging leisure activities, education and health based activities.

Management of risk issues and performance

Staff maintained and had access to the risk register. Staff did not feel able to escalate concerns when required. The registered manager was able to access the risk register and update it as needed. At the time of our inspection the service did not have any items on the risk register.

Staff had mentioned areas where they thought there may be a risk, but these had not been included on the local risk register and they did not feel confident to mention other issues.

The service had plans for emergencies. The service had a business continuity plan in place which detailed steps to be taken in the event of an emergency.

Information management

The service used systems to collect data that were not over-burdensome for frontline staff. The electronic system the service used collected data that fed into the provider's quality assurance systems.

Requires improvement

Wards for people with learning disabilities or autism

Staff had access to the equipment and information technology needed to do their work. Staff recorded patient information into paper files with incidents being recorded electronically. Permanent staff were able to access computer systems.

Information was in an accessible format, although this was not always completed in a timely manner. Information on incidents and route cause analysis was reviewed and there was evidence that incidents were not always completed by staff involved. Where route cause analysis had been carried out, they were often completed over a month after the incident. This was as a result of incidents being referred to the local safeguarding authority, but meant recommendations could be late being implemented.

Staff did not always make the required notifications to external bodies when needed. We found evidence to show the hospital had not submitted some statutory notifications to the CQC when needed. We spoke with the registered manager about this and found that they were unsure of what needed to be reported.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The provider's website gave patients and carers information about events and changes to services. Staff were able to obtain information via the provider's intranet.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. Patients were able to participate in the people's parliament which gave them the opportunity to meet and discuss the service with senior managers.

Leaders engaged with external stakeholders. The registered manager worked with services like commissioners, local safeguarding and Healthwatch to ensure the safety and quality of patients in the service.

Commitment to quality improvement and innovation

Staff did not participate in national audits relevant to the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure patients receive meaningful activity in line with the provider's policy and dedicated one to one time with their named nurse.
- The provider must ensure there are sufficient numbers of appropriately trained staff on duty to cover all observations and to protect patients and staff avoidable harm.
- The provider must ensure that patient risk assessments are regularly reviewed and updated following incidents and when required.
- The provider must ensure that statutory notifications are submitted to relevant organisations as required.
- The provider must ensure that observations are completed in line with the company policy and staff make efforts to engage with patients they are observing.
- The provider must ensure that all relevant staff receive effective clinical supervision.
- The provider must take steps to ensure that staff feel able to raise concerns without fear of retribution.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that de-briefs are carried out for staff and patients following incidents.
- The provider should ensure that agency staff are fully trained and given an induction prior to starting work in the service.
- The provider should ensure that incidents are recorded as soon as possible by a member of staff who was involved in the incident.
- The provider should make efforts to improve the communication between care staff and members of the multi-disciplinary team.
- The provider should ensure that staff make efforts to engage with patients they are observing, in line with the provider's policy.

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 Patients were not provided with 30 hours of meaningful activity per week, in line with the provider's policy. Patients were not able to have dedicated one to one time with staff

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 Not all risk assessments were being regularly reviewed and updated. Patient observations were not being carried out in line with the provider's policy.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service was not submitting all statutory notifications as required under the Health and Social Care Act. Investigations into incidents were not always carried out in a timely manner. Notifications submitted contained wrong information and were not a clear and record of events.

This section is primarily information for the provider

Requirement notices

Staff were not fully supported and did not feel valued. Staff were wary or reporting concerns and were fearful of losing their jobs.

Regulated activity	Regulation
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 There were not sufficient numbers of qualified staff on duty to ensure patients and staff were kept safe from avoidable harm. Staff were not being provided with regular clinical supervision, in line with the provider's policy.