Cedar House

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

Overall summary

Cedar House hospital provides low secure inpatient services for adults with a learning disability or autism who have offending or challenging behaviour and complex mental health needs.

The purpose of this inspection was to follow up on the warning notice that was served by the Care Quality Commission immediately following the unannounced, focused inspection on 21 July 2020. We served the warning notice because the provider was failing to comply with Regulation 12 (Safe Care and Treatment) because of the following reasons:

- Failure to deploy enough suitably qualified, experienced and competent staff to deliver safe care along with a failure by the leadership team at both the hospital and provider level to recognise this
- Lack of robust risk assessment and management of risk resulting in a high number of assaults on staff and patients
- Not carrying out observations appropriately and safely
- Reliance on the use of 'as required' medication (PRN)
- Confusion and lack of understanding about the use of emergency equipment and emergency medicines.

We told the provider it must take immediate action to meet the requirements of the regulation

This inspection was an unannounced, focused inspection. We did not rate the service on this inspection. The previous rating of inadequate overall still stands and the hospital remains in special measures.

At the inspection we found:

- Staffing levels across the hospital had improved and the hospital managers were recruiting more staff and working towards maintaining maintain safe staff levels. An additional member of staff had been allocated for teams on Folkestone ward and the Enhanced Low Secure Service. This meant more staff were available to support observations and manage incidents. The staffing level on Poplar ward had improved and there was no longer only one member of staff working alone.
- We found most observation records we checked met basic standards.
- There was a reduction in over-reliance on as required medication (PRN), following an audit of PRN, and the hospital had started to introduce ways to reduce patient incidents via what it called Calm cards; these outlined behavioural coping strategies that were used before staff gave PRN.

Summary of findings

- The hospital had implemented Positive Behaviour Support (PBS) champions in order to improve the usage of the PBS interventions and reduce incidents. They were working with an external organisation to further develop staff understanding and implementation of PBS. PBS is a recognised method for helping some patients with a learning disability to develop less-challenging ways of interacting with others.
- Managers were being supported to make improvements at the hospital. This included weekly calls from Huntercombe senior managers and input from external organisations, which were providing support to managers to reduce inappropriate placements and carrying out a project with staff to develop a shared vision for the future. Managers were actively focused on providing better care for patients who were inappropriately placed at the hospital.
- The reasons for low morale amongst some staff due to safety had been recognised and the service was working with staff to respond to their concerns and make changes that would benefit them.
- Managers had developed action plans for service improvements. The hospital had a plan in place to improve the environment and we saw new flooring being installed on some of the wards and some bedrooms and a dining room were being painted. There was a rolling programme of repairs.
- During the inspection, we observed positive staff and patient interactions and good use of distraction and de-escalation techniques by staff.
- There were now two emergency bags and two emergency response teams at the hospital and staff were better informed about the use of emergency medicines.

However

- The ward environments on Folkestone, Folkestone ELS, Rochester and Maidstone wards were not clean. There was no regular cleaner for the wards employed by the organisation at the time of the inspection. Night staff had been asked to clean the wards but day staff told us they also had to clean the wards at the same time as working with patients and carrying out their caring duties. Contract cleaners were employed to do a deep clean on the wards monthly and the provider was advertising for housekeeping staff. In laundry rooms on two wards we saw chemicals were open and potentially accessible by patients, and there was loose tubing and items that were potential trip hazards. Bathrooms and toilets were not clean on Folkestone ward and the Enhanced Low Secure Service.
- Between 22 July 2020 and 18 September 2020 there were 11 assaults on patients and 20 staff had taken time off work after incidents. Of the 830 incidents recorded, 11.8% resulted in minor or moderate injury to staff or patients. This meant we were not fully assured that the provider had assessed and mitigated the risks to patients and staff.
- Despite the improvements in staffing levels and the work being done to ensure safe staffing levels, staff we spoke to had concerns about the confidence and competence of staff, as many were new or agency and did not know patients well.
- Staff did not always develop holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff did not always store care records in one place. We found care plans on the electronic patient record system but also some were kept in a shared drive. Sometimes staff could not locate specific information they might need to guide their interventions with patients.

Physical health care plans were not always easy to locate in the electronic record system and some were kept in folders in a shared drive.

- Wards did not always keep detailed enough handover notes to ensure staff on the next shift knew about the patient's needs.
- Two of the wards do not have a separate garden area from the shared hospital grounds, this meant that patients could not always access the grounds when the wards were busy and there were not enough staff on the ward. There were not always enough activities available to patients on wards
- Ward staff told us that some multidisciplinary team members did not have a presence on the wards and

therefore lacked a real understanding of patients risks and challenges presented on wards. Ward staff did not feel supported by some members of the multidisciplinary team.

- Relatives and carers said they could not always visit their loved ones at the hospital and that the provider did not always respond to their concerns. Staff told us that restrictions due to Covid-19 had meant relatives and carers could not always visit their loved ones inside the hospital.

Although, there is still much work to do at Cedar House hospital there had been enough progress with improvements required as identified in the warning notice alongside plans in place to continue the improvements. We have therefore decided to lift the warning notice.

However, we will continue to monitor the hospital closely and will not hesitate to take action should the improvements not continue.

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		

Summary of findings

Contents

Cedar House

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

Summary of this inspection

Background to Cedar House

Cedar House is a specialist hospital managed by The Huntercombe Group, providing assessment and treatment in a low secure environment. The service has six wards and capacity for 39 patients. The hospital provides low secure inpatient services for people with a learning disability or autism who have offending or challenging behaviour and complex mental health needs.

The wards include:

- Folkestone ward is an eight-bed ward for male patients.
- Folkestone enhanced low secure (ELS) ward is a six-bed ward for male patients. This area of the ward provided a service to patients who had particularly challenging behaviour.
- Maidstone ward is a six-bed ward for female patients.
- Tonbridge ward is an eight-bed ward for male patients.
- Rochester ward had three male patients as well as single annexes for another three male patients.
- Poplar ward is a locked rehabilitation ward for five male patients. This ward was outside the secure perimeter fence.

Cedar House is registered to provide the following regulated activities;

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury

Cedar house has been inspected three times in 2020. Prior to the recent inspection, we carried out a comprehensive inspection of Cedar House in February 2020, following which the hospital was placed in special measures and rated inadequate. We then carried out a focused inspection on 21 July 2020 when we served a warning notice.

Our inspection team

The team that inspected the service comprised the head of hospital inspection for the region, three inspectors, two specialist advisors who were nurses with expertise in forensic learning disability services and an expert by experience. The expert by experience had lived experience of caring for somebody with a learning disability.

Why we carried out this inspection

Following the last inspection, the Care Quality Commission served a warning notice due to immediate concerns about the safety of the service and required the provider to improve by 7 September 2020.

This inspection was a focused, unannounced inspection to follow up on these issues that the Care Quality Commission had served to the provider in the previous warning notice.

How we carried out this inspection

As this was a focused inspection, we did not re-rate the service as we only looked at some of the key lines of enquiry across three domains; safe, effective and well led.

Prior to the inspection, we reviewed information that we held about the location. We also sought feedback from professionals. We carried out an inspection visit on 15th September 2020. Following the inspection visit, on 17, 18 and 21 September, we spoke with relatives and carers and staff.

During the inspection process, the inspection team:

Summary of this inspection

- visited five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for and interacting with patients
- spoke with 16 patients who were using the service
- spoke with 11 carers and relatives of patients
- spoke with the registered manager, Doctors, clinical nurse manager and managers or acting managers for each of the wards
- spoke with 21 other staff members; including support workers, senior support workers, nurses
- observed 10 staff and patient interactions
- Looked at 21 care and treatment records of patients
- reviewed 23 medicines records on four wards
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

- We spoke with 16 patients and 11 carers and relatives.
- Four patients told us that staff were nice. They told us they had some positive experiences and some patients enjoyed off-ward activities at the hospital.
- Three of the 16 patients we spoke to told us there were not enough staff and they did not feel safe due to aggression from other patients.
- Carers and relatives we spoke to, gave mixed responses about the hospital. Some told us they had to wait for responses to their concerns and sometimes were not contacted at all. Three relatives said they were not included in discussions about their relative in the hospital and did not know how safe loved ones were. Some carers told us the staff were very good and the garden environment was nice and tidy.

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?

During this inspection we found:

- Four ward-environments were not clean in all areas. Staff had concerns about cleanliness and infection control. There was no cleaner employed at the hospital at the time of the inspection. We saw chemicals open in two laundry rooms where patients could access to do their laundry. This presented a potential risk to patients and this also meant that the hospital did not comply with COSHH requirements. On two wards we found the toilets and bathrooms were not clean. However, contract cleaners were employed to do a deep clean on the wards monthly and the provider was advertising for housekeeping staff.
- Some staff and patients told us they still did not always feel safe. Some staff we spoke to said this depended on the experience of the staff on shift with them. There was evidence of multiple assaults on patients and staff within the three months prior to the inspection. New staff had been recruited; however, many were inexperienced and did not know patients well. Although some agency staff were now regular and included on rotas, a high number of agency staff were still being used which meant that agency staff did not always know patients well.
- The seclusion room on the ELS ward, while mostly adequate, had missing privacy film for patients using the toilet and the adjacent nursing office was being used as a storeroom. We were unable to check if the intercom was working.
- Handover notes were brief and did not always contain information essential to know patients' needs and risks well. This meant staff coming on to a shift did not always know enough about patients. Some staff could not locate handover notes and we were not convinced that they knew what their purpose was.
- The systems in place to manage risk were not fully effective. Three of the 21 care records we saw did not have up-to-date risk assessments. Some staff we spoke to were unaware of the location of ligature audits or where the risks were on the ward.

However:

- At the previous inspection we found that Poplar ward had only one member of staff at night. This had improved since the last inspection.

Summary of this inspection

- There were two emergency bags and two emergency response teams at the hospital and most nurses we spoke to were aware that the hospital stocked Flumazenil for treating benzodiazepine overdose.
- The hospital had a plan in place to improve the environment and we saw new flooring being installed on some of the wards and some bedrooms and a dining room were being painted.

Are services effective?

During our inspection we found:

- Some patient records we looked at included easy-read documents, which was an improvement on the last inspection.
- The service had started to develop ways to implement PBS. We saw 'calm cards' placed in some clinical medicines charts to help prevent use of as required medication (PRN).
- Patients were receiving an annual physical health check

However

- Patient records we reviewed were mostly complete however, they were not always easy to locate.
- Patients' immediate physical health needs were not always being addressed. Physical health monitoring was not always consistent on all wards. Physical health monitoring after the use of rapid tranquillisation had not always been completed.

Are services well-led?

During our inspection we found:

- There was a commitment from senior leaders towards continual improvement and innovation, following the last inspection, although implementation was at an early stage.
- An external organisation was supporting senior leaders. They carried out interviews with staff on site in order to produce a very visual representation of how Cedar House can be its best. Leaders hoped this will enable everyone to build the vision for the service.
- The service had carried out clinical audits on the use of as required medication (PRN) and were implementing changes as a result.
- Staff sickness had been reduced.
- Managers were actively focused on providing better care for patients who were inappropriately placed at the hospital.
- The reasons for low morale amongst some staff due to safety had been recognised and the service was working with staff to respond to their concerns and make changes that would benefit them.

Summary of this inspection

However

- At ward level, staff were concerned about the lack of leadership and presence of ward managers.
- Staff did not always feel supported to care for the patients, managers and members of the multi-disciplinary team were not always present or available for support.

Wards for people with learning disabilities or autism

Safe	
Effective	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

Most wards we visited needed updating and repair. Rochester ward was in poor decorative condition and showed signs of continual damage and temporary repairs to walls, doors and infrastructure. The environment in Folkestone Enhanced Low Secure ward (ELS), despite redecoration, was poor and needed to be repaired on a regular basis due to patient damage.

However, works had started to improve the environment and there was a plan in place to continue this. Bedrooms on Maidstone and Folkestone ELS ward were being repainted. Managers told us that a plan was in place to refurbish wards and painters and a carpenter had been commissioned. New furniture had been ordered and was due to be delivered. A capital expenditure request had been sent to the senior leadership at Huntercombe to refurbish kitchens and bathrooms in 2021.

On Folkestone Ward, the tables and chairs were not clean. On Folkestone ELS and Folkestone ward we saw that toilets and bathrooms were not kept clean. Staff told us that they did not always have time to clean the ward during the day since they were busy working with patients. There were no regular cleaners for the wards employed by the service at the time of the inspection but a post had been advertised. Staff were not always aware of the colour coding on mops and some had been seen using the red bathroom mop to clean kitchens. This meant there was a risk of cross infection. Contract cleaners were employed to do a monthly deep clean on the wards. Some patients and carers and relatives we spoke to also told us the hospital site was not clean. The provider told us they had improved their cleaning schedules and had implemented quarterly deep cleans by night staff following this being raised as a concern at our previous inspections. Staff were not adequately following control of substances hazard to health (COSHH) procedures. We saw that in the laundry rooms on Folkstone and Poplar wards there were open bottles of chemicals on tables that presented a risk of harm for patients. Equipment was not stored securely and rooms were untidy, with many exposed plastic tubing and other potential trip hazards.

The seclusion room on Folkestone ELS did not meet requirements of the Code of Practice. There was no privacy screen in place to protect patients' dignity and respect while using the toilet. We found that the nursing office for the seclusion room was being used as a storeroom.

Folkestone ELS ward did not have access to dedicated outdoor space and had to rely on staff availability to be taken into the main hospital garden area. Patients told us this was rarely possible. This meant patients did not have enough time for fresh air off the ward.

Managers completed ligature audits to identify where the environment might put patients at risk. Ligature audits reflected specific issues found on each ward and a colour coding system was displayed in the nursing office to provide staff with an at a glance summary of higher risk areas. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of self-harming. However, not all staff we spoke with knew where the ligature risk assessment folder was to access it should they need to. This meant not all staff were aware of ligature risks on the ward.

Regular team meetings kept staff informed on the COVID-19 pandemic and there were adequate supplies of personal protective equipment such as gloves and masks. We observed staff wearing face masks throughout the inspection.

Wards sometimes allowed animals to visit and a standard risk assessment was in place for this, however these were not formally, or independently behaviourally assessed. One patient told us they were anxious when a dog was brought to the ward. The risk assessment tool we saw discussed the possible risks presented by patients towards animals but did not include the need to be aware of patient fears about

animals. The policy gave guidelines for staff about managing hygiene but it was not clear whether wards were cleaned immediately after animals had been present on them.

The provider had systems in place to respond to physical health emergencies. There were two emergency bags across the site, which were maintained and checked by staff. The equipment was adequate, checked and recorded. There were two emergency response teams, one for each side of the hospital. This was an improvement since the last inspection.

Safe staffing

Staffing levels had improved since our last inspection and all the wards we visited were fully staffed at the time of the inspection. Managers told us that they had been working to improve staff ratios and deployment in order to reduce risk. They had increased staff levels on Folkestone and the Enhanced Low Secure Service by one staff member per ward. There was a daily staff allocation meeting for managers each morning to help them plan staffing levels and manage gaps. New staff had been recruited and agency staff were regular where possible and were included on the shift rotas.

The provider was using agency staff but most were nurses and support workers who knew the patients and who were on the staffing rota.

We reviewed handover notes which were very brief and not detailed enough for staff to know the patients' needs well. For example, handover notes on Folkestone ward and the Enhanced Low Secure (ELS) ward did not include commentary on patient care plan goals and how these were being met. For example, we did not see handover of information about nutrition intake, use of leave, engagement in therapeutic or meaningful activity, or mental state. Where incidents or concerns were noted, there was no record of what happened prior to the incident or afterwards.

Assessing and managing risk to patients and staff

There was a local protocol in place for summoning urgent support by pulling alarm fobs. Staff checked their radios to ensure they were in good working order before going to the wards and the alarm fobs were checked by the control centre staff daily. The provider told us that staff could raise concerns if there were delays in the response and these were investigated.

Most of the staff we spoke to were trained in formal de-escalation and breakaway techniques.

At the previous inspection, staff told us that they did not feel safe. On this inspection staff told us that they did not always feel safe, and it depended on the experience and knowledge of the staff they were working with on that day. Staff felt unsafe when new or inexperienced staff were on shift. One of the three ward managers we spoke to appeared not to know the risk issues related to the patients on their ward. During the inspection, we observed positive staff and patient interactions and good use of distraction and de-escalation techniques by staff.

We saw risk assessments had been completed in the care records and handover notes included risk issues, although approaches to risk management were not evident in handover notes we saw.

Observation records we saw on Tonbridge Ward and the Enhanced Low Secure Service mostly met requirements. Two out of five records we saw had gaps in recording, missing signatures and some pages were missing. Staff told us these may have been recorded on a separate sheet but were unable to provide evidence of this at the time of the inspection.

Five of the 21 staff we spoke to told us that new staff were often inexperienced and did not always feel confident in working with patients. Four staff we spoke to said they did not always feel safe on the ward. Some staff said they did not always have time to take their allocated breaks.

Three of the 16 patients we spoke to sometimes did not feel safe. Two patients told us that they had been bullied by other patients and one said they had been injured by another patient.

There were high levels of incidents by patients on patients and patients on staff. Between 22 July 2020 and 18 September 2020 there were 11 assaults on patients and 20 staff had taken a total of 60 days off work after incidents. The provider told us most incidents (88%) reported within Cedar House did not result in any injury to either patients

or staff. Of the 830 incidents reported between 22 July and 18 September, 93 (11%) resulted in minor injury/first aid to a staff member or patient, 7 (0.8%) resulted in moderate injury/hospital treatment.

Some carers we spoke to told us they were concerned that patients were not safe and that their loved ones had been harmed by other patients and this was worse during the lockdown as a result of coronavirus.

Poplar ward no longer had a lone working staff member at night. There were now at least two staff on shift at night. This has improved since the last inspection.

Managers told us that they were addressing staff feelings about safety through supervision and meetings and they had responded by increasing staff numbers on Folkestone and the Enhanced Low Secure Service by one staff member each, by recruiting additional staff, ensuring agency staff were regular and familiar with the wards and had improved inductions for agency staff on wards. Some staff we spoke to told us they continued to feel unsupported.

Safeguarding

Staff we spoke to were aware of safeguarding and its importance and were able to give examples of the safeguarding process and how they would raise an incident.

Staff access to essential information

Staff could access essential information about patients via the electronic patient record system and on the shared drive, however this information was not consistent for all patients and sometimes staff were unable to find clinical information. For example, we checked care plans, capacity assessments section 17 leave authorisations and physical health care assessments, and LTS reviews and information was difficult to find as it was stored on various different drives and places, We were not always able to see individualised, easy to read care plans for patients.

Medicines management

On the previous inspection we found that there was overuse of as required (PRN) medications. On this inspection we reviewed 21 medicines records and found that the use of PRN (as and when required) medicines had reduced and the justification as to why it was given matched the clinical notes. There were protocols in place for staff to follow for administering PRN effectively, however these had not been implemented on all wards yet. If there were two PRN medications or more, the doctor had provided a rationale for their use.

On Maidstone and Rochester wards, we saw that each medication folder was individualised and contained what the provider called a Calm card. This was a card that listed ways to manage mood and behaviour in ways that did not include the use of as required (PRN) medicines, such as going for a walk or using a relaxation exercise. We saw two Calm cards that were created using pictograms for people with a learning disability. Some of the medication charts had easy read medication descriptions and individualised information for the patient.

On Rochester ward the clinic room was organised and all medication was in date. Fridge temperatures were checked regularly.

However, on Folkestone ELS the urine test strips were out of date and the medicines cabinet fridges on Folkestone ELS and Poplar ward were unclean and iced up. We told the provider about this during the inspection and they agreed to address it.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Assessment of needs and planning of care

Care records were kept electronically in both the electronic patient record system and a shared drive. Staff did not always know where to find information about patients in either of these systems. Some care records we reviewed were inconsistent in quality and not always personalised. For example, we saw some care records that were individualised and some that were not. Two care plans and one risk assessment were not updated, which meant that staff were not up to date with current risk information. One care plan for observation levels was out of date but had been reviewed in separate notes from a multidisciplinary meeting, so not all staff knew where to find this information.

On Rochester ward information was difficult to find as it was stored in various online locations. We were unable to

find many individualised, holistic or easy to read care plans for patients, however we saw some easy read documents in patients care plans who had a learning disability, which was an improvement since the last inspection.

Care records did not always reflect physical health risks and staff could not always find care plans and risk assessments for patients with diabetes and other physical health issues.

Best practice in treatment and care

The provider had commissioned work from an external provider specialising in Positive Behaviour Support (PBS) to come and do an assessment and provide feedback; and were working with them to develop a project for service improvement. An outcome will be about staff having a tool kit of skills. Upskilling staff and supporting staff.

On the wards we inspected, we saw positive behaviour support (PBS) plans were being created and updated for patients by psychologists and senior support workers. This was an improvement from the last inspection.

Multi-disciplinary and inter-agency teamwork

Each ward had access to a full multidisciplinary team (MDT), including doctors, nurses, psychologists, occupational therapists and support workers, who attended weekly meetings to discuss patient care, but were not based on the wards. We saw a psychologist and a ward manager visiting some wards, however staff told us that the presence of the MDT on the wards was not always consistent. This meant staff did not always have the direct support that they needed on a day to day basis.

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

Leadership

Leaders were working to make positive changes following the last inspection, including daily staff allocation meetings with senior managers and using support from an external organisation to engage staff in service development. These developments and improvements were at an early stage and had not yet had time to take effect, embed or show the benefits

Action plans for service improvements were comprehensive and were focused towards improvements needed.

The provider had commissioned an external agency to provide extra support to members of the senior leadership team to develop an inclusive vision for the service, using an approach called appreciative enquiry. This was a process that used organisational strengths to envision and design a desired future in collaboration with staff. This included interviews and discussions with staff on site to enable all staff to develop the vision.

Culture

Managers told us they were working with staff to understand the causes of staff not feeling safe, by exploring this in supervision sessions and staff meetings. Some staff said they didn't feel safe when new staff join. Although ward managers were not based on the wards, staff could seek support from ward managers via a 'surgery' away from the wards. However, staff we spoke with felt this was not always adequate and said that ward managers were often not present on the wards when they needed immediate support.

Governance

Governance processes had improved at the hospital. The hospital had implemented spot checks of the environment which ensured repairs were done. Security staff supported ward staff to improve their understanding of ligature risk by visiting wards and talking with staff about the risks and how to identify these. A senior handover document was sent around daily to inform all managers about incidents and important organisational information across the hospital, with action plans.

Each ward had a clinical improvement group. Audits and improvements were discussed in multidisciplinary team audit meetings. Managers gave examples of audits that had been carried out. These included audits about as required medicines (PRN) and alarm fobs. These had led to improvements such as providing a rationale for PRN prescriptions and adding Calm cards to medication charts on some wards and discussion of PRN monitoring with pharmacists.

Senior managers told us a patient survey had been sent out, led by the advocate, which focused on safety. Managers said a staff survey was planned to go out later in September.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure patients and staff are safe by continuing to review and reduce incidents of assault.
- The provider MUST ensure the ward environments are safe, clean and in a good state of repair.
- The provider MUST ensure wards are cleaned regularly and consistently to a high standard by cleaners who are trained to use cleaning equipment correctly, including the safe storage of cleaning chemicals according to COSHH requirements.

Action the provider SHOULD take to improve

- The provider SHOULD ensure that clinical audits on physical health records and care plans continue to be carried out and recorded in order to enable staff to learn from the results and make improvements to the service.
- The provider SHOULD ensure physical health needs are recorded appropriately and consistently and audited regularly.
- The provider SHOULD ensure handover notes are more detailed and staff can clearly understand all the important information about patients
- The provider SHOULD ensure new staff and agency staff have an adequate, ward-level knowledge through assessments and more detailed handover information at the start of shifts, to ensure they get to know the patients they are working with.
- The provider SHOULD ensure clinical records are stored in a logical, accessible and organised way, so all staff can easily access them and be informed about patients' needs.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment There are high levels of incidents of patient on patient and patient on staff, this could result in unsafe care and treatment. This was a breach of regulation 12(1)(i) The provider did not always ensure the ward environments were repaired, clean and safe This was a breach of regulation 12(1)(d)