Jasmine Court Independent Hospital

Quality Report

Jasmine Court,
Paternoster Hill, Essex, EN9 3JY
Tel:01992 787 202
Website: www. barchester.com

Date of inspection visit: 03/02/2016
Date of publication: 09/09/2016

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services caring?	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 Jasmine Court as requires improvement because:

- We found several ligature points (a point that someone can attach a cord to strangle him or herself with) throughout the hospital. Managers had identified these in the ligature audit but the provider had done nothing to reduce the risk to patients.
- One member of staff had not completed the provider's training before taking part in in restraints (a physical intervention to manage an aggressive patient). Staff did not document restraints as required by the Mental Health Act Code of Practice.
- We observed staff filling in observation records several hours after they had finished observing patients. This meant we could not be sure that records were accurate or that staff had observed patients correctly.
- Managers did not supervise staff monthly, in line with the providers' policy. Records showed some staff had not been supervised for four months.
- Staff morale was low. Staff felt management did not support them and their concerns were not listened too.
- Medication Administration Sheets (MARS) were not audited appropriately. We found gaps in administration of medications and staff had not written the frequency or amount of medication on the administration chart.
- While regular medication was stored appropriately, controlled drugs were not secure, as the key to the locked control cupboard was kept on the top of the medication cupboard.
- Staff supervision records were not individualised. We found records were the same for several staff, with the only difference being the staff member's name changed.
- Staff told us they had raised complaints and used the whistle blowing policy but had not received any feedback on outcomes from management.
- At least one member of staff did not have a pinpoint alarm. This meant they would not be able to call for help should they be in a position where they were at risk or needed support quickly.
- Blind spots (areas of the ward that were out of sight) meant that staff could not observe patients on all parts of the ward. Closed circuit television (CCTV) or mirrors were not used to reduce risks.

However:

- Staff completed comprehensive risk assessments.
- Staff treated patients with dignity and respect at all times and respected patients' privacy.
- Staff were involved in clinical audits and acted on any concerns these highlighted.
- Staff were aware of the organisation's visions and values and who senior managers were.

Summary of findings

Contents

Requires improvement

Jasmine Court

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

Summary of this inspection

Background to Jasmine Court Independent Hospital

Jasmine Court is located in Waltham Abbey, Essex.

Jasmine Court Hospital is a mixed sex unit with 15 beds. There were 13 patients on the ward when we inspected. Three were detained under the Mental Health Act and six were subject to Deprivation of Liberty Safeguards (DoLS). Jasmine Court caters for patients with varied mental health issues and challenging behavioural needs, people with complex needs and people with histories of substance misuse, and a forensic history (previous criminal behaviour).

Jasmine Court Hospital focuses on rehabilitation, working with individuals, encouraging, and supporting them to maximise their life skills, enabling them to live independently or with minimal restrictions.

The registered manager and the controlled drugs accountable officer was Rodica Odusote.

The regulated activities were;

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

We last inspected Jasmine Court in July 2013. At this time provider met all standards we inspected them against.

Our inspection team

Team leader: Victoria Green

Lead inspector: Lee Sears, Inspector, mental health hospitals.

The team that inspected the service included an inspection manager, two CQC inspectors, and a Mental Health Act reviewer.

Why we carried out this inspection

We carried out an unannounced focused inspection of this provider following concerns identified by the Care Quality Commission.

The inspection concentrated on the safe, caring, and well-led domains as the concerns related to these domains.

How we carried out this inspection

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

- Is it safe?
- Is it caring?
- Is it well-led?

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

During the inspection visit, the inspection team:

- visited the ward at Jasmine Court and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the manager of the wards
- spoke with the regulations manager
- Spoke with six other staff members; including, nurses, support workers and occupational therapists
- Looked at treatment records of 13 patients.
- Carried out a specific check of the medication management on the ward.

Summary of this inspection

- We looked at a range of policies, procedures and other documents relating to the running of 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**:
- The provider carried out a ligature audit of the environment. However, when this identified ligature risks, the provider did not take proactive measures to reduce them. Staff reviewed individual ligature risk assessments for patients and would increase observation is to reduce any risks presented.
- There were blind spots on the female corridor that meant staff could not observe patients on all parts of the ward. The provider had not reduced the risk with mirrors or CCTV.
- The provider did not manage restraint of patients safely. One member of staff had not completed restraint training but participated in restraining patients. Staff had not documented restraint incidents as required by the Mental Health Code of Practice. This meant the provider did not monitor and assess whether staff were using restraint safely and appropriately.
- Patients were not observed safely in line with the providers own policy. Staff did not complete observation records appropriately. There were gaps in observations records. We saw staff filling in forms several hours after the observations had taken place. This meant that observation sheets did not accurately reflect the presenting risks of the patients.
- Whilst the provider stored regular medications safely, they did not keep the separate controlled drugs cupboard key in a secure manner. This meant that access to the controlled drugs was not restricted to authorised staff.
- One member of staff did not have an alarm to call for assistance should they find a patient or themselves at risk. This was contrary to the provider's safety procedures.
- The cleaning audits were not always completed. We found several audits that had gaps where staff had not completed them. This meant that we could not be confident that the provider was safely managing infection control risk.
- Management did not always follow up safeguarding referrals with the local authority. This meant that they were not finding out the outcomes of investigations, could not follow up on any actions they needed to take and learn lessons from incidents.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- Staff treated patients' with dignity and respect. When a patient became agitated, staff were calm and supportive, and guided them to a quiet area where they were able to calm down.
- Patients' were involved in the development of their care plan. Staff documented patients' views within the care plan. Patients' were involved in the review of their care plan.

However:

- Care plans did not reflect all the patients' individual needs. They covered the patient's personal care needs but did not cover emotional and psychological well-being. Staff documented patient views on their care plans, which showed that patients had some involvement in the planning of their care.
- The medical staff completed Do Not Resuscitate forms (DNR), but had not carried out Mental Capacity Assessments to ensure they had tested patients' views and ability to agree. Staff had not reviewed this decision once the patient returned to Jasmine Court from hospital.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Managers did not record staff supervisions appropriately in line with their policies and procedures. Supervision records were not individualised. This meant that we could not be confident that staff were being supervised when the provider had said they had been. The provider was not ensuring they were supporting staff adequately.
- Staff did not receive supervision on a regular basis. Staff we spoke to said they had not had supervision for four months. Records showed gaps in supervision.
- Staff morale was low, as they did not feel supported by management. Staff did not feel management listened to their concerns.
- Staff told us they had made complaints and used the whistle blowing policy. They told us they had not received feedback or outcomes from these complaints.

Summary of this inspection

- Only 83% of staff had received mandatory training, which was below the provider's target of 85%. None of the individual mandatory training courses met the provider's target. Staff compliance with mandatory training ranged between 67% and 83%.

However:

- Staff were involved in clinical audits and these were completed on a monthly basis. Staff then acted upon any actions identified.
- Staff were aware of the organisations visions and values and knew who the senior management were.

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.

- Staff received basic Mental Health Act training, but this did not include the Mental Health Act Code of Practice. We found policies that referenced the Mental Health Act Code of Practice. Management had reviewed these policies in the past twelve months but they did not include the changes to the Code of Practice.
- Section 17 leave forms contained conditions and escort arrangements for leave. Staff completed a risk assessment prior to leave. However, records following leave were not sufficient to assist in the evaluation of the leave. For example, staff did not document patients' views on their leave.
- Staff regularly assessed and reviewed consent to treatment. For example, there was a best interest assessment in place for a patient receiving covert medication.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There were six patients on Deprivation of Liberty Safeguards (DoLS) and four patients awaiting assessment for authorisation.
- Eighty-two per cent of staff had received Mental Capacity Act training as part of their safeguarding training. However, staff did not know which of their patients lacked capacity. Staff were able to tell us how they involve patients in decision regarding their care. One staff member we spoke to demonstrated good knowledge of the Mental Capacity Act and showed us examples of capacity assessments.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Safe	Requires improvement
Caring	Good
Well-led	Requires improvement

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

Requires improvement

Safe and clean environment

- Managers completed a ligature action plan in May 2015. The action plan stated that changes to the environment were 'as required depending on patient profile'. This meant they would complete the work if they admitted a patient who was at risk of ligature. This did not take into consideration the changeable needs of the patient group already on the ward. For example, they had identified that communal bathroom contained ligature points (a point that someone can attach a cord to strangle him or herself with). Consequently, staff told us they always supervised patients using the bathroom, and kept the door locked when not in use.
- Some door closures were ligature risks, for example, in the communal lounge, and hallways. There were ligature points in rooms such as side glass/metal lights in the communal activities room, dining room, and lounge. There was exposed pipework in the visitor toilet that someone could use as a ligature point. This room was unlocked when we first inspected but locked when checked later.
- The ward layout was a square of corridors with a garden courtyard in the middle. This meant there were some blind spots. The provider had not mitigated the risks of the blind spots with mirrors or CCTV. This meant that they could not ensure safety of patient's in these areas.
- The ward had separate sleeping areas for male and female patients, which was separated by a locked keypad only accessible by staff. Male patients were able to access their bedrooms, which were off the communal lounge. However, female patients did not have free access to their rooms and would have to ask staff to let them through the locked area. Males had to access female areas, under supervision of staff, to attend the occupational therapy kitchen. Patient bedrooms had an observation panel in the doors. These were all open without a clear rationale for this. Two staff told us they were too high for them to look through. Patients could close the observation panels from inside their room.
- Staff locked the clinic room when not in use. It was clean and tidy and of adequate size, Staff monitored the room temperature regularly and the room had an air conditioning unit to maintain room temperature. There was a fridge used for storing medication that need to be cool and the temperature was monitored daily. Staff kept the fridge locked and checked and recorded the temperature daily. Staff kept medication in locked trollies as well as a locked cabinet on the wall. We looked at the paperwork for this and found that staff filled it in correctly and it was up to date. We checked a sample selection of medication both patient and stock. We found that they all had expiry dates on the boxes and they were all in date. The provider had arrangements with the local pharmacy for medication provision. The pharmacy completed a six monthly audit. Staff completed a monthly stock check of patients' medication. However, within this cabinet was the controlled drugs cabinet. The Controlled drugs cupboard key was not secure, and was kept on top of the cabinet. This meant that there was potential for the controlled drugs key to be lost or misused.
- Emergency equipment such as the defibrillator and oxygen cylinders were in working order and the oxygen cylinder was in date. However, staff had not completed the weekly checks on the emergency equipment since August 2015. This meant that staff had not taken measures to ensure that the emergency equipment was safe to use in an emergency.
- The provider had a cleaning schedule for communal areas. We checked the housekeeping audits from April 2015 to the time of inspection. Audits for January 2016

were missing. Staff had not filled in all parts of the audit. There were jobs that staff had not completed, such as cleaning shower curtains, which they should complete every 3 months, and moving furniture to clean behind and daily emptying of the bins. There was a strong odour in some corridors and bedrooms. We saw an incontinence pad that staff had left on the floor in a patient's bedroom. Patients did not have individual clinical waste bins in their room. This meant that the provider had not ensured that appropriate cleaning and infection control standards had been met.

- We checked environmental risk assessments including fire safety, COSHH (control of substances hazardous to health), security, and the health and safety monitoring report. The manager reviewed these in July 2015. The fire safety risk assessment included patients that required assistance to evacuate in case of fire. Staff last updated this in September 2015. This had not included a recent admission who was wheel chair bound, and would need assistance to safely exit the building in the event of a fire.
- Patients had call alarms in their rooms and some staff had personal alarms. one staff did not have a personal alarm. This meant thet could be at risk of harm from patients, as they did not have means to call for help. Staff did not offer us visitors alarms.

Safe staffing

- The manager was able to adjust staffing levels according to activity levels on the ward. The providers' day establishment level was two nurses and three health care assistants. On nights shifts they had one nurse, and two health care assistants. We checked the duty rotas for the past three months, which showed that the provider was regularly increasing staffing levels when they had high levels of patient observations. We were unable to clarify whether they were increasing staff levels sufficiently as we could not ascertain how many people they had on increased observations levels on each day.
- The service was sometimes short staffed due to sickness. The week prior to inspection there were three shifts short due to staff sickness. On the day of inspection, the provider had two nurses and five health care assistants. There was one person off sick but despite this, there seemed adequate staff for the activity levels that day.
- The provider used bank staff to cover vacant shifts. The provider had three nurses and ten health care assistants on the bank system. This meant that patients were familiar with staff, which supported continuity of care.
- Staff we spoke to told us that leave and activities are not cancelled due to staff shortages. Leave was usually planned, and adequate staff arranged to cover this. There was an occupational therapist and an occupational therapy assistant who would run the group programme.

Assessing and managing risk to patients and staff

- The providers training matrix showed staff mandatory training was 83%. This was below the providers' target of 85%. None of the mandatory training on the matrix was above the providers' target. The providers training matrix was not accurate as three staff were not included on the list. The manager explained this was due to the fact they started within the last 90 days and were still in their induction period. Once they have completed this, they will be included in the training matrix. The staff did not receive training on dementia despite the fact some patients had a diagnosis of dementia.
- We checked five care and treatment records and looked at the risk assessments for these records. Staff completed a risk assessment upon admission for each patient. Staff used the Sainsbury risk assessment tool to assess risk upon admission. These included falls risk assessments as well as a ligature risk assessment for each patient. Staff reviewed and updated these monthly, or if the risk changed. We received three notifications of falls resulting in injury in the three months prior to our inspection. However, staff told us of at least four more incidents that had resulted in injury that the CQC had not been notified of. We checked the falls risk assessments of those patients, which showed that staff would increase observation levels if a risk of falls was identified.
- Staff did not record observations of people identified at risk appropriately. The provider had three patients on one to one observations, and five patients on intermittent checks (four checks per hour). Two people were level three, (one to one within eyesight); one person was on level four observations, (within arm's reach.) We checked the observation records for these patients. Some of the records for the intermittent checks had gaps where staff had not completed them. Staff had

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

not completed some of the records at the time of the observations, and retrospectively filled them in. One member of staff filled in an observation record for a patient who had been observed by a different member of staff. Both of these patients were level three observations.

- Staff used restraint to administer medication and did not record this as required by the Mental Health Act Code of Practice. This meant staff had not monitored, reviewed, and assessed whether patients were restrained in a safe way. Staff told us they did not often use restraint. They said it was always a last resort, and the focus was on de-escalation. Staff said all patients have individual support plans for managing violence and aggression. Staff received MAPA (management of actual or potential aggression) training. This is a system for the management of aggressive and violent behaviour. Some staff had not received this training. Staff said that staff who had not received training had been involved in restraint and used techniques that the provider had not approved. This meant that the provider had not safeguarded the patient or member of staff from potential injury during restraint.
- The provider did not have a seclusion room and did not seclude patients. Staff told us that if a patient was aggressive they would take them to their room to de-escalate the situation. They told us they did not keep patients in their room and they are free to leave.
- Management did not follow up on safeguarding alerts raised with the local authority. Staff told us they knew how to report safeguarding concerns, but had difficulties getting the results of investigations from the local authorities. The provider did not have regular meetings with the local authority regarding safeguarding concerns. We looked at the safeguarding log. This contained safeguarding alerts staff had raised. We checked the staff safeguarding training. Eighty-two percent of staff had completed all safeguarding training, this was below the providers' target of eighty five percent.
- Whilst staff stored regular medications safely, they did not assure that they were administered safely in line with policies and procedures. We checked the medication administration charts and found some were difficult to read. One chart had a patient's injection medication but did not say the frequency. Staff were administering it fortnightly. We confirmed this was correct with staff. Other issues found were no maximum dose on as required medication on three charts and no frequency on another two charts. Staff had not signed medications as given. There was no documentation of this in the care records. Staff did not safely audit medication administration and MARS (Medication Administration Records). This meant that we could not be sure that patients received their medication in a timely and safe manner.

Track record on safety

- The incident log identified two serious incidents requiring investigation. The log stated the type of incident and a brief description of what happened. However, it did not state the outcome of any investigation. Some staff told us they had reported incidents that were not in the log. This meant the provider was not recording incidents in line with organisational policy.

Reporting incidents and learning from when things go wrong

- The provider uses a paper incident recording system. The manager then investigated all incidents reported. Staff told us they knew how to report incidents when things go wrong, and were aware of what types of incidents they should be reporting. The manager informed us that some staff needed further training in this area. However, staff did not record all incidents, including the when staff had restrained a patient to have medication or escorted to their bedrooms. Staff had not carried out investigations into these incidents. Patterns of patient aggression could not be monitored for cause, and the actions of staff could not be reviewed, therefore lessons could not be learnt or shared.

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

Good

Kindness, dignity, respect and support

- Staff treated patients with dignity and respect. We observed staff interactions with patients and saw staff

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

dealing with a patient who was agitated and aggressive. They managed the situation calmly and effectively, leading the patient out into the garden where they were able to calm down.

- Whilst being shown around the ward, staff would always knock on patient's door before entering. They asked for the patients consent before allowing us to enter the room.
- Staff explained how they met the needs of different patients. Patients had a red folder in their room that contained their care plan. Staff would refer to this if they were unsure of what a patient's needs were. The staff communicated any change in needs through shift handovers and discussed in doctors review meetings.

The involvement of people in the care they receive

- Staff told us when they admit patients they show them around the ward. They said that when possible patients are given a choice of room. Staff informed patients what activities were available and gave all patients an activity schedule. We saw that patients had this information in their room.
- Patients were involved in care planning and risk assessment. We checked the care and treatment records and looked at care plans. Staff completed sections on patient views, which stated patients agreed with the care plan. This showed that patients had some input into their care. Staff told us patients have a red folder in their room that contains their care plan and activity schedule and we saw that this was the case. The red folder also included a 'this is me' life history, which explained some background information as well as likes and dislikes. Staff told us that if they were unable to get the information from the patient they would speak to family and carers. Staff wrote care plans in a style that was focused on tasks staff needed to do to support patients care needs. Staff had not considered the patients emotional and psychological well-being and what support they could provide for this. This meant that care plans were not always patient centred or individualised.
- We found a do not resuscitate form in one patients notes. This was from when staff at to admit the patient to the general hospital. The patient had not signed it but his wife had. We could not find a capacity assessment for this decision and the doctor had not reviewed it since he was admitted to Jasmine Court. This meant that the medical team had not taken into consideration the patient's changing needs and wishes.
- Patients had access to advocacy. The provider used a local advocacy service who would visit the ward. There was information displayed around the ward regarding independent mental health advocates and independent mental capacity advocate. Staff we spoke to knew how to access these services.

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

Requires improvement

Vision and values

- Staff we spoke to knew the organisations visions and values. The provider had the organisations visions and values displayed around the hospital. However, staff told us morale was low and they did not receive appropriate support.
- Some staff were aware of who senior managers were. One staff told us they visit every two months.

Good governance

- We could not be confident that staff were receiving the level of support and performance reviews to carry out their roles safely. The manager did not record supervision accurately. Some staff told us they have monthly supervision, other staff told us they had not received supervision in four months. We checked the supervision notes for all staff and found that the manager had used the same supervision record and photocopied it for several staff, then added the staff names. Other records showed the same topic list used for several staff and the supervisor had not written any detail. Some supervision records were dated when staff were not on shift. This meant that supervision was not individualised for each staff member. We found managers were using four different supervision templates. There was no order to the supervision record keeping and records were not in date order. There were not any individual staff files. This meant it was very difficult to navigate through the files to find information.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff told us the nurses were involved in clinical audits, which they completed on a monthly basis. These included care plan and risk assessment audits. We looked through various audits including housekeeping audit. Some of these were not fully completed and had gaps. This meant that audits had not been regularly reviewed and actions had not been taken to capture the missing information, and ensure safe practice.
- Staff told us that the organisation had an incident log on the computer system and management would review the log and identify lessons learned. The manager would feed back to staff through clinical governance and team meetings. The clinical governance meeting minutes we reviewed showed that incident reports and investigations were part of the agenda. However, we had identified that staff were not recording all incidents, such as restraints, and two incidents that had resulted in injury. Therefore, management had not appropriately investigated these and lessons had not been learnt.

Leadership, morale and staff engagement

- Staff told us they were able to raise concerns with the nurse in charge or the manager. Some said they had made complaints and used the whistle blowing procedure but had not received any feedback or outcomes from these complaints. Staff felt that they were not listened too and management did not respond to concerns.
- Staff gave a mixed response regarding morale. Three of the six staff we spoke to felt demoralised and unsupported by management. They felt the manager spent most of the time in their office and did not come onto the ward very often. Staff said they felt that the workload was often high and this caused a lot of stress. Staff said they had raised this with management but they told them staffing was adequate.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must implement an action plan to remove ligature points as far as is practicable.
- The provider must ensure all staff have completed MAPA training prior to becoming involved in restraining patients. This is in line with their own policies and procedures, to ensure that patients who become aggressive are cared for safely.
- The provider must ensure that when patients are restrained, these incidents are recorded in line with the Mental Health Code of Practice, 2008.
- The provider must inform the CQC of all notifiable incidents under the Registrations Act.
- The provider must improve procedures and documentation of patient observations
- The provider must provide regular and accurate supervision to staff to ensure that staff are supported to safely carry out care to patients.
- The provider must respond to complaints and whistle blowing concerns appropriately, and feedback outcomes to the complainant.
- The provider must ensure that the Mental Health Act Code of Practice is included in Mental Health Act training

Action the provider SHOULD take to improve

- The provider should develop and implement an action plan to reduce blind spots in the unit where practically possible.
- The provider should issue all staff, both regular and agency with pinpoint alarms to ensure patient and staff safety.
- The provider should ensure that the controlled drug key stored securely.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider was not documenting patient observations in a safe way and in accordance with organisation policy. The provider must take action to ensure observations are documented in line with organisational policy. The provider had identified a number of ligature points but had not acted to reduce these risks. The provider must develop an action plan to state when they will remove ligatures points. this was a breach or regulation 12 (1) (2)(a) (2)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider was not acting on complaints and whistle blowing concerns. The provider must act on complaints, whistle blowing concerns, and communicate outcomes with the complainant. The provider was not documenting patient restraint in with the Mental Health Code of Practice. this was a breach of regulation 17 (1) (2)(c) (2)(e)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **How the regulation was not being met:** The registered manager had not notified the Care Quality Commission of some incidents reportable under the Registrations Act. The provider must ensure that they adhere to the conditions of the Act.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not providing or documenting supervision in line with organisational policy. The provider had not ensured all staff had received mandatory training. Mental Health Act training did not include the updated Mental Health Act code of practice. This was a breach of regulation 18 (2)(a)