Barchester Healthcare Homes Limited - Forest Hospital

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-569958986	Forest Hospital	Maltby ward	NG184XX

This report describes our judgement of the quality of care provided within this core service by Forest hospital. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Forest Hospital and these are brought together to inform our overall judgement of Forest Hospital.

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

Forest care home staff from the same site had been used in emergencies on the hospital unit due to short staffing. This had caused confusion amongst staff about the differences between the care home and hospital. There had been a recruitment campaign with many new starters taking up post. Induction programmes were in place. However these were not effective because staff had not completed all the programme, or had to deal with situations before policies and procedures had been read and consolidated. For example, staff told us they had not seen the observational or complaints policies. Staff were not provided with performance information or action plans arising from audits and incidents. The lack of information meant that there were no team objectives. Appraisals, managerial and clinical supervision were not being undertaken regularly. Staff told us they had not received specialist training in caring for people with Parkinson's and Huntington's disease, which the hospital were providing specialist care for. We found that there was a lack of leadership being provided at clinical and senior management level.

Admission criteria were not used during pre-assessment to admit patients. The hospital's purpose was to provide rehabilitation, however the case mix resembled continuing care. There was no collective decision making about admissions and inpatients care as the psychiatrist, psychologist, occupational therapist (OT) visited on different days and did not have multi-disciplinary meetings.

On the day of our visit, newly recruited nurses were in charge with inadequate supervision. The nurses had not been inducted to use the defibrillator. The sign for the first aider was out of date. Not all staff had alarms to summon help. There were confusing medication protocols for giving medication as required (PRN). At one stage of our visit the nurse left the ward with the keys to the clinic room which contained the medications and resuscitation equipment. A "general services association system" was used to manage violence and aggression; The company had changed to the use of the management of actual or potential aggression (MAPA) in 2014. However not all staff at the hospital were trained in this. This meant that there was a mixture of approaches being used which placed patients at risk of injury with differing techniques being used.

Physical health assessments were not clearly recorded. We found records where personal care had not been signed for. Activities were not actively promoted; the activities programme was out of date on the board. There was a lack of involvement of carers and patients in care plans. "This is me "and "about you "plans were not fully completed. Communication tools and easy read literature were not available. There were limited menu choices available. There were no audit records of the number of hospital appointments that had been cancelled.

The number of incidents, safeguarding alerts and complaints were low. There was no assurance that all that needed reporting was reported. The reporting systems from the ward to the board and from the board to the ward were weak. This meant that there was no early warning to the board that things may not be right. It also meant the team were not receiving information that could help them improve the service.

We found that the hospital was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010) for regulations 13, 20,22 and 23 and have issued compliance actions. We also issued warning notices for breach of regulation 9 and 10.

We will consider these regulations within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that come into force on 1 April 2015 in our follow up inspections.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

The service was not safe.

- No risk plans to manage ligature point. This meant that staff did not consider the individual risks to patients.
- There was no clearly identified first aider to provide aid in an emergency. Qualified staff had not been shown how to use the defibrillator which was a potential risk during resuscitation.
- Three staff who were involved in undertaking observations said they had not seen the observation policy and were involved in undertaking observations.
- The number of incidents and safeguarding alerts reported were low. Managers were not confident that all incidents and safeguarding alerts were reported.
- New staff were not inducted into the risk assessment tool used. This could lead to the potential of risk assessments not being thoroughly completed.
- Medication protocols for medications to be given when necessary and some medication charts had not been signed and dated.
- There were no effective systems in place that informed staff of lessons learnt from incidents safeguarding alerts andserious untoward incidents, either from within the hospital or from the organisation.

Are services effective?

The service was not effective.

- Staff told us they had not received training in the care of people with Parkinson's and Huntington's disease.Staff were not aware of any national institute of clinical excellence (NICE) guidance which underpinned the care given. Health of the nation outcomes scale (HoNOS) were not always completed. Staff were not aware of the outcomes of the care provided.
- Staff had not participated in clinical audits, nor were they aware of audits that had taken place. The results of audits such as the ligature audit and the quarterly Barchester management quality system audit had not been shared nor were the action plans.
- Managerial and clinical supervision was not taking place. Newly appointed staff were not supervised. Induction training was not comprehensive.
- Regular and effective multi-disciplinary meetings did not take place because members of the team worked on different days.

Summary of findings

The psychiatrist also had to undertake care programme approach (CPA) and tribunal work which meant that ward rounds did not always take place. Patients were supposed to be reviewed every three weeks and this did not always occur.

Are services caring?

The service was not caring.

- There was lack of patient and carer involvement in care plans so that their views were taken into account. “All about you” and “this is me” plans were incomplete which if completed. If completed would have enabled staff to understand the individual needs of the patient.
- There was separate bowel movement recording folders and personal care folders which did not relate to the care plans. It was unclear how these folders were used. We found that personal care records had not been signed for a number of days for all patients.
- There were care records in which stated “do not resuscitate” . There was no clear rationale as to why and whose decision it was and when they should be reviewed.
- No surveys had been carried out to collect patient and carers views on their experience of the service provided, so that improvements could be made.

Are services responsive to people's needs?

The service was not responsive.

- Admission criteria was not used when deciding on who should be admitted. This meant that for some patients this hospital might not be the most appropriate setting to receive treatment.
- The psychiatrist, psychologist and OT visited on different days and so did not meet to make a full clinical team decision to admit a patient..
- There were a lack of activities provided and the uptake of activities was not audited or evaluated.
- Communication tools and easy read information were not used to provide information in a format that patients with limited verbal skills could understand.
- Staff we spoke with had not seen the complaints policy and did not know what the process would be. This meant that patients and carers may not have been encouraged to make complaints.

Are services well-led?

The service was not well led.

Summary of findings

- There was a lack of understanding of the purpose and vision of the hospital and how it linked into the wider organisation vision and values.
- Common policies and exchange of staff between the hospital and care unit led to confusion about the differences between the hospital and care unit.
- There was no sharing of performance information. Lessons learnt from incidents, safeguarding alerts and audits were not shared with the staff. There was no service user feedback. There were no team objectives.
- The governance systems of reporting information from the ward to the board and feedback from the board to the ward were weak. This meant that the provider did not have effective early warning systems in place that would highlight potential risks.

Summary of findings

Background to the service

Forest Hospital is a purpose built facility for adults under 65 years of age. The hospital provides care to people with organic mental health conditions such as dementia, Huntington's and alcohol related brain injury, The hospital consists of 15 beds on Maltby ward. 11 beds were occupied. Six of the patients were detained under the Mental Health Act.

Our inspection team

The team included two CQC inspectors and two Mental Health Act reviewers.

Why we carried out this inspection

We inspected this service in responseto concerns raised by CQC adult social care inspectors who had visited the care home on the same site on the 2 and 3 March 2015 and found issues that related to the hospital. We also received whistleblowing concerns.

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?

During the inspection visit, the inspection team:

- visited Maltby ward on the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients.
- spoke with four patients.
- spoke with four carers of patients.
- spoke with the unit manager, acting manager and a regulatory manager.
- spoke with 12 other staff members; including doctors, nurses ,rehabilitation assistants, occupational therapists.
- spoke with a visiting best interest assessor, advocate and a commissioning case manager.
- observed two staff meetings.
- looked at seven medication records of patients.
- looked at seven care records.

We inspected Forest hospital in January 2014 and it was compliant for care and welfare of people who use services, safeguarding of people who use services from abuse and requirements relating to workers. A MHA monitoring visit was carried out in September 2014.

What people who use the provider's services say

- Carers said that they felt involved in their relative's care. The hospital kept them informed. Carers were invited to care programme approach (CPA) meetings.
- Carers were generally satisfied with the care their relatives were receiving. Some reported more activities should be available.

Summary of findings

- One patient said they were bored as there was nothing to do.
- Several patients had limited verbal communication and we found that communication aids were not being used. There was no easy read literature.
- No carer or patient surveys had been undertaken about the service offered.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Physical health and mental health risk assessments must be carried out and recorded.
- The hospital must ensure that there is access to the clinic room in an emergency, that staff know how to use the defibrillator and know who the first aid person is. All staff must carry alarms.
- The hospital must demonstrate adherence to the Mental Health Code of Practice by;-
  - Requesting a second opinion appointed doctor (SOAD) review within time scales and submission of MHA section 61 reports.
  - Adhering to the medication regime on the treatment certificate.
  - Providing MHA section 132 rights information in a format that is easily understood by the patients.
  - Ensuring regular audits and monitoring of the MHA takes place.
- Case note files must be ordered for staff to find the relevant information to provide care easily. Care records must record the personal care given. The rationale and process of decision making regarding resuscitation must be clearly recorded and reviewed.
- Full clinical team meetings must occur to consider potential admissions and to review individual patients care and progress
- Managers must ensure all incidents and safeguarding concerns are being reported. Trends, lessons learnt and action plans must be shared with clinical teams.
- Systems for the use of restraint must be consistent across the staffing provision. The practice we found placed patients at risk of injury as a result of differing techniques being used.
- Medication protocols must be reviewed and appropriately authorised. Medication charts must be accurately completed
- Care plans must reflect patient and carer involvement.
- Patient, carer and staff views must be sought to support development. Admission criteria were not used when deciding on who should be admitted. This meant that for some patients this hospital might not be the most appropriate place to receive treatment.
- Communication tools and easy read information must be available.
- Staff, patients and carers must be aware of how to complain and informed how complaints will be managed.
- Appraisals, managerial and clinical supervision must be provided to all staff.
- Newly recruited staff must be given adequate induction and familiarised with all policies and procedures and risk assessments.

Action the provider SHOULD take to improve

- The communal area toilet should be repaired and signage should work to show occupation.
- Patient public telephones should afford privacy.
- Staff should be trained and supervised in providing activities. The uptake of activities should be monitored.
- Staff should know the purpose of the unit and be provided with specialist training in order to provide evidence based care.
- Patients should have a varied choice of meals. People at risk of choking must be supervised at meal times.

Barchester Healthcare Homes Limited - Forest Hospital

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Forest Hospital	

Mental Health Act responsibilities

- Treatment certificates were not always attached to the medication charts. This meant that staff would not know under which legal authority they were treating a patient, and would not know if the medication was in accordance with the treatment certificate.
- A MHA section 62 was used to give emergency medication. However no second opinion appointed doctor (SOAD) request was made for several weeks following this. The SOAD requested a MHA section 61 report after four months. Documentation to confirm this had been done were not found.
- One treatment certificate for a non consenting detained patient stated that lorazepam was to be gradually reduced and withdrawn in six weeks from date of the certificate. We found that the drug was given for more than six weeks.
- Records reviewed showed that there were some good capacity assessments and these informed care plans. However they did not show that capacity assessments were reviewed.
- MHA section 17 Leave forms were signed by the responsible clinician. Risk assessments prior to authorisation were not robust. Risk assessments before taking patients on leave were not recorded. Evaluation of the leave was not made. Patients and carers were not given copies of the leave form.
- MHA section 132 rights information were given and were repeated, however it was not given in a format that was easily understandable for the patient.
- Information about independent mental health advocates (IMHA) was given. However the information was not available in an easy read format.

Detailed findings

- There were no regular audits to ensure the MHA was applied correctly or any lessons learnt shared.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were introduced to the Mental Capacity Act (MCA) as part of their induction programme.
- It was common practice to make Deprivation of Liberty Standards (DoLS) referral for patients when they were discharged from their MHA section.
- A record reviewed showed that one standard DoLS request gave, as the name of the person most involved with the patient, the name of a nurse who had only started work in the hospital the day before our inspection.
- A best interest assessor was visiting the hospital to carry out an assessment on the day of our inspection. This assessor had made a recommendation that a patient was to be offered activities to engage in. The activities had not been undertaken.
- Records reviewed showed best interest decision assessments had been carried out in relation to giving covert medication for one detained patient.
- Staff confirmed they made referrals to an independent mental capacity advocate.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

- No risk plans to manage ligature points, this meant that staff did not consider the individual risks to patients.
- There was no clearly identified first aider to provide aid in an emergency. Qualified staff had not been shown how to use the defibrillator which was a potential risk during resuscitation.
- Three staff who were involved in undertaking observations said they had not seen the observation policy.
- The number of incidents and safeguarding alerts reported were low. Managers were not confident that all incidents and safeguarding alerts were reported.
- New staff were not inducted into the risk assessment tool used, This could lead to risk assessments not being thoroughly completed.
- Medication protocols for medications to be given when necessary and some medication charts had not been signed and dated.
- There were no effective systems in place that informed staff of lessons learnt from incidents safeguarding alerts, serious untoward incidents, either from within the hospital or from the organisation.

Our findings

Safe and clean ward environment

- There were numerous ligature points, partly due to the need for adaptations for disabilities and to support the needs of older people.. Ligature audits were carried out to assess risks; however the one shown to us was dated January 2013. There was no action plan in place following the ligature audit. Care plans did not individually risk assess for the environmental risks. Staff we spoke to had not seen the ligature audit or management plan nor had it been discussed in team meetings.
- The ward was a mixed sex ward with single bedrooms with en-suite shower room. There were single sex areas. The corridor to the women's area was locked off. One woman was in a bedroom outside the female only area, so she was not afforded the same female segregated space as the other women. There was a lounge and dining room and nurse's office. Staff needed to be present in these areas to observe consistently
- The notice stating who the first aider was out of date as the person had left the hospital some months previously. Staff rotas did not identify who the first aider was for the shift. We asked staff who the first aid person was for the day shift. It was identified that it was the unit manager. It was not clear what would happen if this person was off site or in another part of the building.
- There was a very small clinic room which was accessed through the nurses' office. Only one registered nurse had the keys to the room which stored the resuscitation bag containing oxygen and airways. At one stage during our visit the nurse with the keys was off the ward, so there was no access to the clinic room. The defibrillation unit was in the nurses' office. Both qualified nurses on duty confirmed that no one had shown them how to use the defibrillator. This meant that patients were at risk should immediate resuscitation be required.
- The hospital did not have a seclusion room as it was a rehabilitation unit.
- The ward area was clean, well- furnished and decorated. However we found a dirty pillow in the clean laundry cupboard. Rehabilitation assistants completed a daily job sheet for mopping floors, wiping hand rails, cleaning the sluice, dishwasher, emptying bins and laundry bags. The check lists were signed daily. Cleaning duties meant that rehabilitation assistants were not wholly involved in direct patient care.
- One communal toilet did not flush. The toilet door lock did not show if it was occupied or not. We observed one patient rattling the door whilst the toilet was occupied by another patient.
- Most staff carried alarms so that assistance could be summoned in an emergency. However there were a few staff that had not been provided with an alarm which meant that staff could have been at risk and there could be delays in calling for assistance in an emergency. Alarms were tested weekly by the maintenance man. Patients had access to nurse call systems.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Safe staffing

- Managers told us that they worked on a ratio of three patients to one staff member to enable flexibility of giving one to one support when required. The two qualified staff on duty had not been informed what the core numbers of staff should be. On the day of the visit there were six rehabilitation assistants on duty. Staff worked a shift pattern of 12 hours.
- The hospital did not use a recognised tool for identifying the number of staff required to meet the dependencies of the patients. Staff told us that the unit was a locked rehabilitation ward. However the case mix was more like a continuing care ward because many of the patients' conditions were such that there would be on going deterioration. Some patients required two or three staff to carry out physical interventions.
- Managers reported that retention of staff had been a problem because staff had not been aware of the level of personal care and management of challenging behaviour that would be required and had expected to be undertaking rehabilitation. Some staff had left because of this.
- Figures provided by the hospital indicated insufficient staffing levels. Between November 2014 and December 2015 the hospital employed five whole time equivalent (wte) mental health registered nurses with the exception of December when there were four wte. There were 18 wte rehabilitation assistants rising to 24 in February 2015. There were between one and two nurse vacancies. The hospital said it had between one and two vacancies for rehabilitation assistants, yet we noted an increase of six posts in February.
- The number of shifts filled by agency between November and December 2015 were between 0 -2. In January this rose to 45 and in February to 81. Sickness rates in this period rose from 40% (12) in November to 68% (21) in December and 118% (31) in February 2015. Eight staff left in these four months.
- On the day of our inspection one of the qualified nurse had started in February 2015 and another had started on the ward two days before following a brief induction. Neither had been given the opportunity to consolidate their induction or were being given adequate supervisory support.
- Staff told us that staffing has improved recently and that there had been significant staffing shortfalls. On the week of our inspection, there were four new staff going through induction. This meant the unit will be staffed by a significant number of new starters.
- Patients were given one to one time to meet their hygiene needs, however staff and records were not able to confirm that one to one time with a named nurse was given as therapeutic time.
- The qualified nurses were observed to be carrying out tasks in the office and delegating to the rehabilitation assistants.
- Medical cover was provided through a service level agreement with Nottinghamshire Healthcare Foundation Trust. A named consultant provided two three-hour sessions a week. Psychiatric cover out of hours and during the consultant's annual leave was provided by Nottinghamshire Healthcare Foundation Trust. In an emergency it would take a psychiatric consultant approximately an hour to visit.
- A psychologist was also provided by Nottinghamshire Healthcare Foundation Trust one day a week under a service level agreement.
- An occupational therapist was externally contracted to visit one day a week. Speech and Language therapist input was upon request through GP referral. .
- A GP attended the hospital formally once a week, and undertook visits to see patients when required during the week. Out of hours cover for the GP was provided by an out of hours GP service.
- The activities coordinator post had been absorbed into the staffing numbers due to staff shortages. We were informed that an activities co-ordinator post was being advertised.

Assessing and managing risk to patients and staff

- One staff member undertook detailed pre admission risk assessments. Staff we spoke with were not aware if admission criteria existed. There was no admission criteria that were being used. There was discussion with the psychiatrist and unit manager if a patient was admitted. No full clinical team decision to admit was being made.
- Whilst the hospital advertised that it provided care for adults under 65 years, there were patients on the ward aged over 80 years.

Are services safe?

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- Pre admission assessments reviewed referred to other mental health risk assessments that would be done post admission. These referred to the health of the nation outcome scores and psychological assessments however there was little record of these being done.
- The Sainsbury clinical risk assessment tool was being used to carry out risk assessments. The qualified nurses on duty confirmed that they had not been shown the mental health risk assessments. We also saw a Morgan risk assessment in use to assess mental health risks.
- Physical health risk assessments used were the Waterlow pressure ulcer assessment scale, a nutrition assessment tool and a falls assessment tool.
- Three staff members we spoke with had not seen or read the observation policy. This meant that staff were carrying out observations without an understanding of what was expected.
- Two patients were on 1:1 observations, they had limited verbal communication skills. There was limited interaction between the staff and patients. We saw a patient on 1:1 observations walking several metres ahead of the staff member, the patient walked into a wall and knocked their head. A second staff member assisted and both discussed seeking an increase in observations to 2:1. We were informed the patient was tired, as they could not lie down in bed because their room was being painted. There was no contingency plan in place to enable the patient to go to another empty room whilst decorating was going on.
- There were window panels in bedrooms doors that could be opened to undertake observations. The observation panel in one bedroom door could not be closed. This did not give privacy as people walked past this bedroom to go into the main day room.
- **Assessing and managing risk to patients and staff**
- Verbal de-escalation was used to reduce agitation levels. Staff were trained in breakaway training. The hospital used the "General Services Association" system for restraint and staff only used arm restraint. Some staff had undertaken the recently introduced MAPA training. This meant that a staff member needed to work with someone who had had the same training which caused difficulties. No prone restraint was used. Behaviours and triggers of patients were discussed.
- There were notices on the door to the ward informing informal patients that they could request to leave the ward by asking a member of staff.
- The staff did not undertake blanket routine searches of patients or room searches without risk asseesments.
- Seclusion was not used in the hospital.
- Falls assessments were carried out. There were seven falls reported from January 2014 up to February 2015. These resulted in two patients having fractures. Patients were seen by the GP following falls.
- There were 191 incidents reported from January 2014 to February 2015. The majority were related to patients' physical aggression. Incidents were broken down into numbers per patient. However it was not clear if they were used as part of a functional analysis to discuss positive behavioural support, as staff did not know and rehabilitation assistants were not part of the clinical team discussions..
- There were 13 safeguarding referrals made from January 2014 up to February 2015. Safeguarding training had been provided for staff during induction. There were no checks in place to confirm that staff were accurately reported safeguarding. Safeguarding's were also recorded as incidents. The summary of safeguarding's and the summary of incidents for January 2015 we were provided with did not match up.
- Staff told us they would contact the nurse in charge to raise a safeguarding concern. The nurse in charge would speak to the safeguarding team to confirm receipt of the safeguarding concern. We looked at a safeguarding concern raised, a form had been completed, and it was also linked to the care records. The outcome of the safeguarding was not documented in the care record. The outcome was not recorded in the care files, and was put on an electronic database which staff did not have access to.
- Patients had two medication charts one for mental health medication and another for physical health medication. This meant that there could be potential for errors to occur.
- Medication management policies were available, including covert medication and as required (PRN) medication. Staff had access to recent publications such as British National Formulary to advise them on medicines in use.
- Buprenorphine patch and stock levels corresponded with the controlled drug register.
- We found two medication charts where individual drugs had not been signed by the responsible clinician and the medication had been given to patients.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Staff reported that stocks of medicines were not held on site. Patients would have to wait for newly prescribed medicines to be delivered by an independent pharmacy company during week days.
- A medicines stocktake was carried out by staff by recording the number of tablets left on a drug chart in red.
- There was potential for confusion especially for agency staff as some patients had protocols for PRN medication. The PRN protocols were not always signed, dated, or reviewed. This included in one case midazolam injection which was not prescribed. The medication chart of another patient showed a drug had been written up in a confusing manner that could lead to a high dosage being administered in 24 hours.
- Rapid tranquilisation was given by qualified nurses. Rehabilitation assistants carried out observation every 15 minutes and would sit outside the room.
- Medications requiring cold storage was stored in the fridge. The fridge temperatures were checked daily.
- Errors relating to medication stocktake or administration were reported as incidents.

Track record on safety

- There were no effective systems in place that informed staff of lessons learnt from incidents , safeguarding incidents and serious untoward incidents, either from within the hospital or from the organisation. Staff confirmed that that these were not discussed with them.
- Team leaders in the hospital did not receive performance management information in a format that would enable them to see trends and use information to make management decisions or change practice. There were no examples given of changes in practice as a result of learning from incidents.

Reporting incidents and learning from when things go wrong

- We saw an accident record folder; this had nothing documented in it from September 2014.
- Staff completed an incident form and this was sent to the ward manger. Staff said they did not know what happened after that. The majority of incidents reported related to patients being verbally or physically aggressive, with some falls and medication errors. Body maps were used to show where bruises and injuries occurred.
- Managers told us that they could not be certain there was accurate reporting of all incidents. A new form had been introduced in October 2014. There were concerns that the form was not adequate for the service.
- Two members of staff gave examples of when they had debriefed a member of staff following an incident or receiving a debriefing. This took the form of the nurse in charge talking to the person and giving 10 minutes away from the ward environment. There was no recording of the debriefing having taken place. No other support systems were considered or publicised. One member of staff told us that they had not received a debriefing following an incident.
- We spoke to a visiting commissioner who was concerned that incidents were not reported in a timely manner to commissioners.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

- Staff told us they had not received training in the care of people with Parkinson's and Huntington's disease.Staff were not aware of any national institute of clinical excellence (NICE) guidance which underpinned the care given.
- Staff had not participated in clinical audits, nor were they aware of audits that had taken place. The results of audits such as the ligature audit and the quarterly Barchester management quality system audit had not been shared nor were the action plans. . Health of the Nation Outcomes Scale (HoNOS) were not always completed. Staff were not aware of the outcomes of the care they provided.
- Managerial and clinical supervision was not taking place. Newly appointed staff were not being supervised. Induction training was not comprehensive
- Regular and effective multi-disciplinary meetings did not take place because members of the team worked on different days. The psychiatrist also had to undertake care programme approach (CPA) and tribunal work which meant that ward rounds did not always take place. Patients were supposed to be reviewed every three weeks and this did not always occur.

Our findings

Assessment of needs and planning of care

- Patients did have 72 hour care plans in place whilst assessments were being completed. We found that many of the assessments that were identified as being required in the pre admission plan were not recorded in the care notes. These related to psychology assessments, OT assessments, physical assessments, and Waterlow pressure ulcer assessments..
- A GP visited formally every week and in response to calls during the week. Physical health assessments on admission were carried out by the GP. These were not clearly recorded in the care records.
- At the time of our visit one patient was in the general hospital with pneumonia following a recent admission to the hospital.
- A district nurse came to provide care for ulcers. The hospital were managing peg feeding (a tube surgically inserted into the stomach). Dental and specialist appointments outside the hospital were facilitated. However we found that there was no record how many appointments had been delayed or cancelled due to staffing pressures.
- Bloods were taken for investigation by an external phlebotomist from the GP surgery.
- The hospital was visited by a specialist nurses for Parkinson's and Huntington's disease. They were expected to write in the clinical team records and give a handover to the nurse in charge. There was no system in place to audit that this was taking place. There was no input directly into the clinical team meetings. Staff told us they had not received training in the care of people with Parkinson's and Huntington's disease.
- Care records were manual handwritten records. The files were disorganised and were difficult to navigate. Staff who were new to the ward would not be able to quickly update themselves.
- We saw a separate folder which recorded personal care and room cleaning for each patient. It stated if people had received personal care, teeth brushed, showered and if the bed linen had been changed. Some of the boxes for these were ticked without signatures by the rehabilitation assistants. We found that one patent had no records for receiving personal care for the 4/5/6/7 March 2015, other patients had between two and four days where no signatures' to confirm personal care had been delivered. The daily records did not confirm either that personal care had been given. It was unclear why this information was separate and not recorded in the patients care plans.
- **Best practice in treatment and care**

- There were very few audits carried out. Those that were related to; a quarterly management quality system audits, ligatures, medication and care plans audits. A health and safety audit was carried out in July 2014.
- Staff had not participated in clinical audits, nor were they aware of audits that had taken place. The results of audits such as the ligature audit and the quarterly Barchester management quality system audit had not been shared nor were the action plans. The Barchester management quality audit had been undertaken in November 2014. This tool had not identified some of the basic weaknesses in systems and processes.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff were not aware of any national institute of clinical guidance which underpinned the care provided .
- Health of the nation outcome scores were not always completed. Staff were not aware of the outcomes of the care they were providing.
- There was little evidence of positive behavioural support plans in place.
- **Skilled staff to deliver care**
- The range of mental health disciplines input into the hospital was insufficient to support rehabilitation or continuing care. The psychiatrist, psychologist and OT came to the hospital one day per week and on different days to each other. This meant they did not meet as a clinical team to discuss the care of individuals to ensure that care plans were multi-disciplinary and integrated. Given the number of patients with limited verbal communication the clinical team lacked a dedicated Speech and Language therapist (SALT).
- All referrals for SALT and dietician went through the GP. There were delays in accessing these professionals. The SALT we spoke with was not familiar with the hospital because SALTs attending the hospital come from different teams. This meant that there was no input in to the weekly clinical team discussion and no continuity of professional care for the patient.
- Staff told us and records confirmed that management and clinical supervision was very infrequent. One member of staff newly in post said they were asked to sign off another staff members probationary period check list during a night shift. The staff member was concerned about her ability to do this for some of the items listed, as they had little knowledge and experience of them.
- Staff received two week induction training. However two staff said that not everything on the induction programme had been covered. Induction consisted of an introduction to the company, e learning such as fire training and shadowing staff on the ward. One staff member told us they had not undertaken de-escalation training on induction nor had they done first aid or equality and diversity training.
- We asked four staff about the policies that should have been covered during their induction. Staff could not remember or show they had knowledge of the policies such as complaints, whistleblowing, harassment, grievance, medicines management, observations or resuscitation.
- We were concerned about the lack of support and supervision of new people on induction or just having completed their induction. During a shadowing shift with an agency nurse who had not been there before, the new starter had admitted a patient, without being shown the hospital admission process used by the hospital. The second day of shadowing resulted in the staff member doing observations all day and peg feeds without supervision. The third shadowing day resulted in undertaking medications and looking after a new admission without supervision. This new starter was informed that another new starter would be shadowing them. This meant that new staff were showing other new starters what to do without having completed their probationary period or confirmation that they were able to undertake their duties competently.
- Another new starter on the second day on the ward was undertaking medication administration without confirmation of medication management competencies.
- General System Association (GSA) training had been done by some staff and others were trained in MAPA. One staff member told us that they had not received GSA training until six months after starting the post. This meant that different systems were being used and affected how restraint was managed and reported.
- We were given a staff report which was dated July 2013 giving verification of the professional registration checks and driving licence. These should be undertaken annually
- The organisation had suspended staff in order to investigate the systemic failings that had occurred.

Adherence to the MHA and the MHA Code of Practice

- Qualified staff stated that they required further training on the MHA and Code of Practice. They were not able to locate copies of the MHA and code of practice to refer to.
- Two rehabilitation assistants we spoke with did not know what section 17 leave was and how it differed from leave undertaken by informal patients.
- We found one detained patient who did not have a treatment certificate attached to the medication chart. This meant that staff would not know under which legal authority they were treating a patient, and would not know if the medication was in accordance with the treatment certificate.
- We found section 62 of the MHA had been used to give emergency medication in November 2014 as the person

Are services effective?

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did not have a treatment certificate in place. However no SOAD request was made until the second week in December. When the SOAD visited a decrease of medication was requested and for a section 61 report in four months to report on progress. This did not occur.

- We found a treatment certificate for a non-consenting detained patient dated 6/01/2015 which stated that lorazepam was to be gradually reduced and withdrawn in 6 weeks' time from date of the certificate. A dose had been given on the 10 March 2015 which was more than 6 weeks. We brought this to the attention of the nurse prescriber who confirmed the last dose had been given on that day.
- Records reviewed showed that there were some good capacity assessments and these informed the care plans. However they did not show that capacity assessments were reviewed.
- Records reviewed showed best interest decision assessments had been carried out in relation to giving covert medication for one detained patient.
- Six out of the 10 patients were detained under the MHA.
- Section 17 Leave forms were signed by the responsible clinician. Records reviewed showed that the risk assessments prior to authorisation were not robust. There was no clear protocol for undertaking risk assessments before taking patients on leave. There was no record of each episode of leave being reviewed or patient's views sought. There was no record of carers or patients being given copies of the form. Old forms were not archived or crossed through. There was a separate folder in which a record of the patient's description was made when they went out on section leave, and a single evaluative comment of "good" made of the experience. There were only two records made in the folder dated the 13/12/14 and 30/12/14.
- Section 132 rights information was given and was repeated however it was not given in a format that was understandable easily for the patient. Information about independent mental health advocates (IMHA) was given. The information was not available in an easy read format.
- One patient we spoke with did not know about their rights to an IMHA or the independent mental health tribunal.
- Patients had received hospital manager's hearings.
- There were no regular audits in relation to ensuring the MHA was being applied correctly or sharing of any lessons learnt.

Good practice in applying the MCA

- Staff were introduced to the MCA as part of their induction programme.
- We found that it was common practice to make DoLS referral for patients when they were discharged from their MHA section.
- A record reviewed showed that one standard DoLS request gave, as the name of the person most involved with the patient, the name of a nurse who had started work in the hospital the day before our visit.
- A best interest assessor visited the hospital to carry out an assessment on the day of our inspection. This assessor had made a recommendation that a patient was to be offered activities to engage in. There was no record of the activities being provided.
- Records reviewed showed best interest decision assessments had been carried out in relation to giving covert medication for one detained patient.
- Staff confirmed they made referrals to an independent mental capacity act advocate.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

- There was lack of patient and carer involvement in care plans to support their views being taken into account. "All about you" and "This is me" plans were incomplete. If completed these would have enabled staff to understand the individual needs of the patient.
- There was a separate bowelmovement recording folders nd personal care folder which did not relate to the care plans. It was unclear how these folders were used. We found that personal care records had not been signed for a number of days for all patients.
- There were care records in which stated "do not resuscitate" which did not have a clear rationale as to why and whose decision it was and when they should be reviewed.
- No surveys had been carried out to collect patient and carers views on their experience of the service provided, so that improvements could be made.

Our findings

CARING

Kindness, dignity, respect and support

- We observed staff to be kind and considerate, displaying willingness to learn**.** We spoke with three patients, who had limited verbal communication. We observed limited patient staff engagement. The rehabilitation assistants had not been provided with the tools to understand the behaviours being displayed as a form of communication or provided with communication tools they could use. One staff member said that they were not attuned to one patient with limited verbal communication, although some staff could understand the person. There was little awareness of what this might mean to the patient.
- We saw one instance where a rehabilitation assistant diverted a patient wishing to leave by taking her to the café for a hot chocolate. However on the whole we found staff did not show understanding of individual needs. A patient with a potential risk of choking was allowed to eat in their bedroom without supervision. One rehabilitation assistant carrying out 1:1 with a patient managed to stop them banging their head. However was not able to use any techniques that would divert the patient from walking into walls.
- One patient had problems with their mouth and the GP was going to examine this. This patient had lost their false teeth a week ago and they could not be found.

The involvement of people in the care they receive

- Staff we spoke with were not aware of admission processes to orient patients admitted to the ward. They were not aware of any welcome packs.
- We saw documents called 'it's all about you' and 'this is me' to try and personalise care, however not all files were complete. We noted that an audit report had identified improvements were needed. It was unclear if any efforts had been made to implement the recommendations.
- Records reviewed showed some care plans to be very prescriptive with no record of patient and carer participation. One care plan referred to the patient throughout as 'the person' not by their name.
- We found one record in which holistic assessments had been done with patient and carer. There was a care plan restricting telephone access from a patients carer. However to maintain contact an old phone was used to record a voice message for the carer to hear.
- We found a separate folder that recorded patient's bowel movements. They were not completed daily, only if bowels had moved and only for four patients. Daily records in the patient's files did not record this information unless the patient was incontinent. Staff could not explain why this information was recorded separately and how it was used.
- Care records did not show advance decisions in place. There were care records in which stated "do not resuscitate". The process and rationale for this decision was not always recorded. In one care record the decision had been made after discussion with the spouse of the patient. It was not discussed with the patient as it might have caused distress to them, nor were the decisions reviewed.
- Patient files were not well organised in a logical order, we reviewed some notes that were not clearly written. For example the care programme approach (CPA) minutes for one patient were written in a confusing manner and made no sense. The disorganisation of files

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meant that new staff commencing their duties would not be able to find the most up to date information to assist giving care. This could present a potential clinical risk.

- The independent mental health advocacy service was provided by POhWER. They had provided presentations about their role to the staff.
- Referrals were made to the advocates by the hospital. The advocates had access to rooms at the hospital to meet patients in private. Access to patient records was given. The advocacy service reported that they received invitations to CPA meetings and their views on behalf of the patients were taken into account at meetings. Advocates said they were not always informed about incidents that had happened with their clients until they visited.
- Advocates had observed that there had been difficulties with staffing levels when they had visited the hospital. For example, they said that when agency staff were on duty, their knowledge of the patients was not good. When visiting the ward they were advised to look at the patients records when enquiring about patient risk, care and treatment. This was discussed with the modern matron who was proactive in providing an in depth handover prior to advocates seeing patients.
- There was no multi-faith room to meet patient's spiritual needs.
- We spoke with three carers who said that staff contacted them to inform them of the patient's day and any incidents that had occurred. They were kept informed about medication changes.
- The three carers we spoke with said that staff had a good understanding of the patient's needs. One carer reported having phone contact each evening or when the patient was distressed or anxious and staff they needed their support to help the patient calm down.
- Flexible visiting was provided taking into consideration carers travelling distances.
- Carers were invited to CPA meetings and to meet the consultant. Two carers confirmed the consultant had met with them and explained the patient's treatment plan.
- One carer reported that the hospital was making efforts to find places nearer to the family for the patient to reside in and they felt involved in the process.
- Three carers reported that the hospital placement provided better care than the previous placement elsewhere. Staff were friendly, kind and caring. Staff were supportive with one of the carers in organising a taxi to the acute hospital when a patient had suffered a fracture. Another carer was pleased that the staff had noticed the patient had an arthritic hip and organised treatment, as this had not been picked up on the previous placement.
- Carers felt able to make a complaint if needed, and would have no concerns approaching the hospital.
- There were no feedback cards in the comments box put out by the hospital
- A patient survey should have been undertaken in January 2015 and was not .
- Patients or carers were not involved in decisions about their service or involved in recruitment of staff.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

- Admission criteria was not used when deciding on who should be admitted. This meant that for some patients this hospital might not be the most appropriate setting to receive treatment.
- The psychiatrist, psychologist and OT visited on different days and so did not meet to make a full clinical team decision to admit a patient..
- There were a lack of activities provided and the uptake of activities was not audited or evaluated.
- Communication tools and easy read information were not used to provide information in a format that patients with limited verbal skills could understand.
- Staff we spoke with had not seen the complaints policy and did not know what the process would be. This mean that patients and carers may not have been encouraged to make complaints.

Our findings

Access, discharge and bed management

- We spoke to a commissioning manager who had three patients placed on the ward. The manager reported that what was being commissioned was a locked rehabilitation ward specialising in Huntington's disease and dementia care. The arrangements also included assessing appropriateness for placement on the nursing home side of the provider's service if long term care was needed. The contract for placements was on the understanding that staff had received additional training in Huntington's disease. Staff we spoke with had not received this training
- Access to beds was via referrals from clinical commissioning groups. A pre assessment was undertaken to check that the patient was suitable for placement at the hospital. No admission criteria were used. The decision to admit was not a full clinical team decision. One person had been refused admission by the psychiatrist because of unsuitability for the placement. Two patients had recently been transferred to another provider because they were not suitable for the services being offered.
- Patients were from Derbyshire, Nottinghamshire, Doncaster, Walsall and Lincolnshire areas. The average length of stay was not clear. There were attempts being made to provide a placement closer to home for one patient.

The ward optimises recovery, comfort and dignity

- The ward did not have an activity room, although there were other activity rooms that could be used.
- There was a comfortable visitor's room and café where we saw one detained patient having a drink with a staff member. Visits could take place there with staff present.
- Patient telephones were seen in the dining room and day room. They did not have privacy hoods so that people could talk in private. Patients were allowed mobile telephones.
- Staff gave the post to each patient and asked them to read it to them. A record was made of the type of post, content and where it was kept. The next of kin were asked if they wanted a copy of the letter. Hospital appointments letters were put in the patients care files. There was no policy for opening the post nor how refusal would be managed. There was a potential for invading a person's privacy through this restrictive practice .
- A smoking shelter was provided in the garden and patients were allowed there hourly, staff did not see this as restrictive practice. We observed one patient using this space.
- The door from lounge area to garden was locked. Staff said patients could ask to go out when they liked. However a staff member was not observed to be present in lounge area all the time so that patients could do this and some patients had limited verbal communication.
- Food was freshly cooked on the premises. A menu was displayed in the dining room. However patient choice was limited by what was sent to ward. Two choices were sent to the ward, if more patients requested one of the choices these would not be met.
- Patients did not have access to hot water for drinks without staff supervision. Cold drinks were available.
- Patients did have the choice of personalising bedrooms. However, we did not see much personalisation.
- There were lockable cupboards with a safe inside wardrobes to keep personal belongings in.
- The activity programme displayed on the notice board was out of date. Activities offered were chair exercises,

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

gardening, going out to the bank or shopping. Baking sessions were advertised several times during the week however they did not happen due to staffing. One member of staff told us that they had just been made aware of an activities folder that day. One carer told us that they would like their relative to be undertaking activities. We did not observe any activities taking place. We saw patients mainly watching TV or in bed. One patient said that they were bored and the days were long. We did not see independent living skills promoted. We reviewed one case record and found that no activities had been recorded. We looked at all care records and found there was no signature for the 4, 5, 6 and 7 March 2015 to confirm that personal care had been carried out.

- We observed a meal time and saw staff standing and eating, whilst patients ate in silence. Meal times were not being made into a social occasion.
- There was a mini bus available to take patients on outings. Only one staff member was able to drive the mini bus, so outings were limited.
- The uptake of activities was not audited. The Occupational Therapist (OT) had in the previous week asked for a coding sheet to be filled in to evidence that patients were offered 25 hours activity per week. This included daily living activities such as personal care. Many of the rehabilitation assistants were new in post and were not sufficiently trained to motivate and support people engaging in activities. For example, we were told that music had been put on to encourage patients to undertake chair exercises, but patients had not been interested.

Meeting the needs of all people who use the service

- There were large bathrooms for people with physical disabilities, with a hoist for bathing available.
- There were grab rails along walls to provide support to patients.
- We found that some patients had limited verbal skills. We did not see communication tools used to provide information in a format that the patients could understand.
- There was a lack of easy read and pictorial information literature available.
- There was no multi faith room to meet patient's spiritual needs.

Listening to and learning from concerns and complaints

- Staff we spoke with could not remember having read the complaints policy or what they would do if someone wanted to make a complaint.
- There was one complaint received for 2014. A patient had gone missing and was brought back by a neighbour. A member of staff had sworn at the neighbour. As a result of the formal complaint, site security was improved. The gate through which the patient had left the hospital was made more secure. The staff member undertook 'training in customer service skills'.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

- There was a lack of understanding of the purpose and vision of the hospital and how it linked into the wider organisational vision and values.
- Common policies and exchange of staff between the hospital and care unit led to confusion about the differences between the hospital and care unit.
- There was no sharing of performance information. Lessons learnt from incidents, safeguarding alerts and audits were not shared with the staff. There was no service user feedback. There were no team objectives.
- The governance systems of reporting information from the ward to the board and feedback from the board to the ward were weak. This meant that the provider did not have effective early warning systems in place that would highlight potential risks.

Our findings

Vision and values

- Staff were unclear about the purpose of the hospital. They were confused about the difference between the hospital and the care home. There were common policies that had caused the confusion. Exchange of staff from the care home side to the hospital side reinforced the confusion. Staff told us that they thought the only difference was that the hospital side had detained patients.
- There was no clear clinical vision shaping the hospital facility as to whether it was a rehabilitation or continuing care unit. No discussion from the company had taken place with the visiting clinical team about the clinical model of care to be established . Patients were admitted without reference to an admissions criteria.
- Staff applyed for posts on the understanding that they were applying to come to a rehabilitation facility. However the patient mix resembled a continuing care facility. This had resulted in some staff leaving.
- The ward and clinical team did not have any team objectives. No performance information was shared with the team that would help shape their objectives. The team were not familiar with the organisations objectives.
- There was a lack of leadership by the immediate managers and a lack of leadership in the ward. Staff were confused about their roles and responsibilities.

Good governance

- The systems for ensuring staff were inducted properly, received mandatory and specialist training and were appraised and supervised regularly were not effective.This meant that a large number of new staff did not understood their roles and responsibilities in delivering care to a complex patient mix.
- Barchester Healthcare national regulation team audits the hospitals. Forest hospital had an audit by the team two years ago. The organisation had risk profiles that identified hospitals that may be at risk so that a scheduled audit visit could take place.
- Staff were not involved in audits. Audits were not effective in changing practice as information was not shared with the team.
- Staff reporedt incidents and safeguarding concerns. However there was no assurance that all incident and safeguarding concerns that should have been reported were reported.
- The staff team did not receive performance reports to develop action plans.
- There was reliance upon agency staff to cover shifts. A number of new staff had been recruited, many of whom had only been with the hospital a few months or weeks. They were responsible for showing other new staff what to do, when they themselves had not had opportunity to consolidate their learning.
- There was a risk register dated 2013 -2014 which identified risks related to finance, business, safeguarding, violence and aggression, ligature risk, infection control, mandatory training and housekeeping. There were no effective monitoring of the risks or effective plans in place
- We looked at governance minutes and found the last meeting had occurred on the 3/12/14 and a further one planned for the 28/1/15. We were not provided with documentary evidence that this had occurred. The minutes of the meeting in December identified action plans that were to be put on the intranet and feedback to be given to areas. Staff could not confirm this had happened.

Leadership, morale and staff engagement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff reported they would use the whistle blowing hotline and raise concerns. Staff we spoke with had not read the whistle blowing, bullying and harassment and grievance policies.
- Staff told us that morale had been low due to staffing, however recruitment was occurring and this was improving morale.
- One manager confirmed they were offered leadership and management training however this was cancelled.
- The majority of staff were new to the organisation and were not able to confirm if there were opportunities to input into service development.

Commitment to quality improvement and innovation

- There was no participation in national quality improvement programmes.
- Barchester Healthcare had responded to the feedback given by the CQC adult social care inspectors by implementing management changes at the time of our inspection. There was oversight by the acting divisional director, interim unit manager and a dedicated unit manager for the hospital. Signs made clear which part of the building was a hospital and which the care home. Staff working across both services was stopped. The management sent an hospital interim action plan within a week of our visit.
- On the day of our visit a manager from the Barchester Healthcare trainer was present to start implementing MAPA training for all staff.
- A daily meeting was established at 10am each day. We observed this meeting occurring. The purpose was to discuss staffing, incidents, safeguarding and issues of concern, so that management were aware and could provide staff support and supervision. Staff were told at the meeting to expect unannounced visits by senior managers to ensure changes in practice was taking place and to provide support.
- A staff meeting was observed in which there was discussion with staff about the differences between the hospital and care home. Staff were encouraged to speak out. Discussion took place on individualised patient centred care approach. Training for staff was discussed. One staff member used the term "coloured carer" this was not challenged.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.** **How the regulation was not being met** • There were medication protocols in place which were confusing, not signed or dated. • One patient was on a drug longer than the treatment certificate specified. • Four people had been given medication that had not been signed by the doctor. • Treatment certificates were not attached to the medication charts. This means that staff would not know under which legal authority they were treating a patient, and would not know if the medication was in accordance with the treatment certificate. • A MHA section 62 was used to give emergency medication No second opinion appointed doctor (SOAD) request was made for several weeks following this. The SOAD requested a MHA section 61 report after four months which was not done. • One treatment certificate for a non consenting detained patient stated that lorazepam was to be reduced and withdrawn in six weeks' time from date of the certificate. We found that the drug was given for more than six weeks. **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 come into force on 1 April 2015 and will be used in our follow up to this compliance action.**

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. **How the regulation was not met** • There was no dependency tool used to determine staffing numbers according to individual need. • There had been short staffing which had led to lack of activities and cancelled hospital appointments. • Specialist training had not been provided for staff relating to Huntingtons or Parkinsons diseases. • Induction training was not comprehensive. • Newly recruited staff were not supervised. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 come into force on 1 April 2015 and will used in our follow up inspections.

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 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by— receiving appropriate training, professional development, supervision and appraisal; How the regulation was not met • Staff inductions were not comprehensive • Appraisal , Management and clinical supervision rarely occurred.

This section is primarily information for the provider

Compliance actions

- Professional development was not provided to support the case mix on the ward.
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 come into force on 1 April 2015 and will be used in our follow up inspections.

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **20.**—(1) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of— a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; How the regulation was not met ; • We looked at all care records and found there was no signature for the 4, 5, 6, 7 March 2015 to confirm that personal care had been carried out for one patient. Ten others had between 2 – 4 days where no signatures to confirm care had been given had been made . Care records did not confirm if personal care had been given. • care records did not reflect carer and patient involvement. Case note files must be ordered for staff to find the relevant information to provide care easily. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 come into force on 1 April 2015 and will be used in our follow up inspections.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA (Regulated Activities) Regulations 2010 Care and welfare of people who use services.** The registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of: (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user, (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. **The enforcement action we took:** A warning notice was issued to be compliant by 30 May 2015. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 come into force on 1 April 2015 and will be used in our follow up inspections.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

This section is primarily information for the provider

Enforcement actions

Regulation 10 HSCA (Regulated Activities) Regulations 2010 Care and welfare of people who use services

The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

(2) For the purposes of paragraph (1), the registered person must—

(b) have regard to—

(i) the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19, (c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to—

(i) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user

ii) the conclusions of local and national service reviews, clinical

audits and research projects carried out by appropriate expert bodies;

The enforcement action we took:

A warning notice was issued to be compliant by 30 May 2015.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 come into force on 1 April 2015 and will be used in our follow up inspections.