The Huntercombe Hospital - Roehampton

Quality Report

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

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

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

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

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

Overall summary

We have not rated this service as this was a focussed inspection.

We found the following areas where the service needed to improve:

- Mandatory training rates for permanent staff was low in several areas. This included safeguarding vulnerable adults. These training rates had remained low since the last inspection in July 2015 therefore we are taking enforcement action.
- Care plans were not always detailed and personalised to the patient. Patient records did not consistently show evidence that staff involved the patient in developing their care plans. Staff did not record when a patient was not able to participate. These issues were only found on Upper Richmond ward, and although there had been some improvements since the last inspection, they were not seen in all patient records. This results in a continuing requirement notice.
- Although staff assessed and rated risks for individual patients, they did not record why they made a change in the risk rating.

Summary of findings

- At the last inspection in July 2015 we found that there were not always enough staff on Upper Richmond ward to deliver safe, high quality care and treatment. At this inspection there were enough staff on each ward to meet the requirements of safe staffing set by the hospital. However, there was a high use of agency staff on all three wards. The service had recruitment strategies in place and employed a number of agency staff regularly to ensure they were familiar with the wards.
- At the last inspection we found that cleaning rotas showed tasks on Upper Richmond ward were not always completed as regularly as they should have been.At this inspection some areas on and off the wards did not appear clean. Feedback from patients indicated staff did not keep communal bathrooms clean.

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

- An advocate visited the wards regularly to engage with patients. Patients were aware of this. The advocate had regular meetings with the hospital director to discuss issues brought up by patients.
- The clinic room appeared visibly clean and tidy. Staff had access to a range of equipment for emergency use.
- Staff recorded and reported safeguarding incidents and other incidents appropriately.
- Nursing staff received supervision every eight weeks. This was in line with the provider's policy and Nursing and Midwifery Council guidance. Staff said teams worked together well and that they felt supported by permanent staff colleagues and by managers.

Following the inspection we served a warning notice requiring the service to ensure at least 80% of permanent staff received training in eight areas of low compliance. This needed to take place by 18 November 2016.

Summary of findings

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Services we looked at
Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Our inspection team

Team lead: Natalie Austin Parsons

The team that inspected Huntercombe Hospital Roehampton consisted of two CQC inspectors, two specialist advisors who work as a nurse and a psychologist with clinical experience of psychiatric intensive care units and one expert by experience. An expert by experience is a person who has had experience of using the type of service we inspected.

Why we carried out this inspection

This was a focussed inspection to follow up the progress from the last inspection which took place in July 2015.

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 the three wards on the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the hospital director and deputy hospital director
- spoke with 14 other staff members; including ward managers, doctors, nurses and social workers
- spoke with the advocate for the service
- looked at eight treatment records of patients
- carried out a specific check of the medication management on four wards
- looked at a range of policies, procedures and other documents relating to the running of the service

Information about The Huntercombe Hospital - Roehampton

The service provides 39 psychiatric intensive care beds for patients across one male and two female wards. On the days of inspection there were 33 patients admitted to the hospital.

We have inspected Huntercombe Hospital Roehampton five times since 2010 and reports of these

inspections were published between March 2012 and November 2015.

At the last inspection in July 2015, Huntercombe Hospital Roehampton was found to be requiring improvement in three of five domains. These were in the safe, effective and well-led domains. The regulations breached were person-centred care, safe care and treatment, good governance and staffing.

This inspection took place to see whether the provider had made improvements in the areas outlined as necessary from the previous inspection.

Summary of this inspection

What people who use the service say

Patients we spoke with said staff were present and available on the wards and were generally caring and respectful. They did note that there were a lot of new staff that came in frequently. Most patients said staff knocked before entering their room. One patient said the service had been helpful to get them on a medication that worked well for them.

Most patients said the environment, particularly bathrooms, could be cleaned more regularly and were often unclean. Feedback about food was generally positive. Patients said they were aware of how to make a complaint and some had done this when they had wanted to.

Several patients said that they would like to speak to staff in more detail about their medication. This included general information which medication they were on, but also what was being given each time.

The service took part in a patient-led assessment of the care environment two months before the inspection. The results showed that scores for five areas, including food and appearance, were rated between 88% and 100%. The rating for privacy, dignity and wellbeing was 89%.

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?

We found the following areas where the service needed to improve:

- Less than 80% of permanent staff had completed mandatory training in eight of 19 areas required. These rates remained low following the previous inspection, where less than 80% of staff had completed training in nine of 15 areas.
- Staff used a risk assessment tool to assess and rate risks for individual patients. Staff reviewed and rated each risk weekly. Staff did not keep a written record of why a change in the risk rating was made.
- There was a high use of agency staff use across all three wards. The service was aware of this and had recruitment strategies in place.
- Some areas of the wards and corridor areas off the wards did not appear clean. Records of feedback from patients showed they had raised this as an issue previously.

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

- The clinic room appeared visibly clean and tidy with a range of equipment for emergency use available and easily accessible.
- The number of staff on duty on each ward matched those determined by the hospital to have safe staffing numbers. This was an improvement from the last inspection.
- Staff were trained to use de-escalation techniques and physical intervention. Staff did not often use seclusion.
- Staff recorded and reported safeguarding incidents and other incidents appropriately.

Are services effective?

We found the following areas where the service needed to improve:

- At the last inspection in July 2015, we found that care plans on Upper Richmond ward were not personalised, detailed, or did not show evidence of patient involvement. During this inspection we found some improvement in these areas but in some cases, this had not improved. There were inconsistencies in how staff completed and recorded information in care plans.
- On Upper Richmond ward staff recorded patient needs as their diagnosis or their behaviour.
- Some patients were prescribed 'as required' medicines. Staff consistently recorded the occasions that these medicines were given in clinical notes, however the reasons for this were not always clearly recorded.

Summary of this inspection

- Supervision rates for non-nursing staff, for example occupational therapists and ward doctors, was not regularly recorded.

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

- Nursing staff received supervision every eight weeks. This was in line with the provider's policy and Nursing and Midwifery Council guidance.
- An advocate visited the wards three time a week and had regular meetings with the hospital director to discuss issues brought up by patients.

Are services well-led?

We found the following areas of good practice:

- At the last inspection in July 2015, there had been a period of significant transition in management. During this inspection there was a newly appointed hospital director who was supported by a deputy hospital director. The senior management team for the site attended regular meetings.
- There were several regular meetings for senior staff to receive and discuss information about the wards. These included a risk management committee for the three wards and a monthly research and audit meeting. Ward staff also held monthly clinical improvement groups.
- Staff we spoke with said the teams worked together well. They felt supported by permanent staff colleagues and by managers. Several staff said they enjoyed their jobs and it was rewarding.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act 2005 (MCA) was mandatory for staff and 62% of staff had completed this training in the last 12 months.

Staff we spoke with had an understanding of the MCA and were able to describe when it would be considered and used.

Staff referenced patients' capacity in their clinical notes, however, for one patient, there was no record of a capacity assessment taking place where staff documented that the patient did not have the capacity to be involved in their care planning.

Acute wards for adults of working age and psychiatric intensive care units

Safe	
Effective	
Well-led	

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Safe and clean environment

- Ward layouts allowed staff to observe all parts of the ward. At the last inspection in July 2015, we noted that open bedroom doors could sometimes block views of the bedroom corridors. This was not observed during this inspection.
- The service had domestic staff who were responsible for cleaning the wards. There had been a vacancy for one member of domestic staff. The provider had filled this position on the day before the inspection. Cleaning records showed there were some days where tasks were not been marked as complete. Some areas of the wards and corridor areas off the wards did not appear clean. For example, there was food and crumbs on a mat in the de-escalation room that staff said had not been used in several days. On Upper Richmond ward the communal bathrooms there were stains on the floor and there was a smell of urine. We also saw food plates and cutlery left on a water dispenser and uneaten plates of lunch left in the communal areas. Not all patient bathrooms on Lower Richmond ward had soap available on the first day of inspection. This was fed back to the service at the time. Records of feedback from patients also showed that they had raised concerns about the cleanliness of bathrooms as an issue previously. Some patients we spoke with said sometimes the bathrooms became unclean and the mugs for hot drinks were not always as clean as they could be. A response from the service outlined that the plastic mugs were sterilised and washed after each use. The mugs stained easily due to the material they were made out of. A patient led assessment of the care environment which took place in the three months before the inspection showed that cleanliness was rated high, at 98%.
- The clinic room appeared visible clean and tidy with a range of equipment for emergency use available and stored clearly. Records showed staff checked the medicines fridge temperature daily to ensure it remained within the necessary range to store medicines safely. Emergency equipment was stored on Kingston ward and was available for use by staff on wall wards. We saw records that staff regularly checks of the equipment and highlighted action to be taken where necessary.

Safe staffing

- The number of staff on duty on each ward matched those determined by the hospital to meet the needs of patients. During the day and night there were two qualified nurses on duty at all times. They were supported by at least four health care support workers. At the last inspection in July 2015 we found there was sometimes a shortage of staff on Upper Richmond ward. During this inspection we found this was not the case. We looked at the staffing rota for Upper Richmond ward for the two months before the inspection and three weeks of day and night shifts in detail. The required number of staff on duty was met on all occasions. Where necessary ward managers increased staffing numbers, for example if a patient needed additional one to one support. The rotas showed that at times, up to seven health care assistants could be working alongside nurses. A sample of five daily ward reports from the two months before the inspection also showed that there were two qualified staff on duty on each day and night shift, supported by at least four unqualified members of staff.
- Throughout the inspection the number of staff on shift reflected the needs of the patients. There were staff present on the ward at all times. There were also staff to carry out one to one observations with patients who required this. We observed patients attending lunch in the dining room and socialising in a calm environment on the wards. If patients became upset or agitated, staff responded promptly to them and their needs.

- There was a high use of agency staff use across all three wards. The service was aware of this and was working to recruit more permanent staff in a number of ways. This included offering a financial incentive to staff who applied to permanent positions. To develop a consistent staff team during this time, a number of agency staff had been signed up to six month contracts with the hospital. The result was that a mixture of permanent, contracted agency and uncontracted agency staff were working together to meet the safe staffing levels for the wards. This resulted in a high use of agency staff on duty on a shift. For example, in the two days before the inspection on Upper Richmond ward, three of eight qualified nurses were permanent staff. Two were contracted agency staff and three were uncontracted agency staff working bank shifts. For the unqualified staff, 12 were contracted agency staff and 12 were uncontracted agency staff working bank shifts. There were no permanent unqualified staff on this ward. This results in patients seeing a high number of different staff and lack of continuity in the same staff group.
- At the last inspection in July 2015 we found across the wards that less than 80% of staff had completed training in at least nine of 15 mandatory areas. This included fire safety and infection prevention and control. During this inspection we found that training rates remained under 80% in eight of 19 areas. This included safeguarding vulnerable adults, information governance and fire safety.

Assessing and managing risk to patients and staff

- Staff used a risk assessment tool to assess a patient's risk when they were admitted. This tool included several areas or possible risk and had a rating scale to measure the severity of the risk. Records we looked at showed there were risk assessments in place for all patients. Risks were discussed and updated on the electronic patient record during weekly ward round meetings.
- At the last inspection in July 2015 we found that on Upper Richmond ward staff completed these risk assessments inconsistently. For example risk assessments completed by different staff within a few days of each other identified different risks for individual patients. At this inspection we found this was no longer the case. One risk assessment was completed initially which was not duplicated by different staff identifying different risks.
- At the last inspection in July 2015 we found that on Upper Richmond ward the severity of risks for some patients was rated differently on different dates. There was no written explanation of how and why this change had taken place. In this inspection we found this had not improved. In care records on Upper Richmond Ward, staff discussed and recorded risks at weekly ward rounds, however the reasons for any change in risk score was not recorded. Staff managed risks whilst on the ward, but the level of detail required to explain changes did not reflect the way that risk was managed. For example, for one patient their risk of absconding increased by two scores from one ward round to the next. There was no explanation of why this had increased or narrative description of the part or current risk apart from the score. During the inspection we observed several examples of staff having an awareness of individual patient risk and managing this with the patient in a respectful way. For example, allowing a patient to keep as much privacy as possible whilst in the bathroom, although there were some behavioural risks associated with them being alone in a bathroom. We observed that notice boards in nursing offices, that were not visible to patients outside the office, outlined the current risks for patients and their observation levels. Staff said this was updated after the weekly ward round. Staff used a traffic light system to highlight the level of risks for each patient. However, this was not reflected on the electronic care records.
- There were several examples where initial risk assessments could not be fully completed as the patient was too unwell to engage and/or this was their first contact with services so staff did not have a written history for them. Staff noted gaps in information with a "don't know", which was an option on the risk inventory assessment form. For one patient on Upper Richmond ward, staff completed a plan to source information externally where possible following an initial risk assessment, however, there were no dates for this to be completed by and over five days had passed with no recorded action.
- Staff were trained to use de-escalation techniques and physical intervention. Each day two staff from each ward were allocated to respond to raised alarms across the site if an incident requiring physical restraint took place. Staff recorded incidents of restraint daily and reported monthly to a clinical governance meeting. Minutes from

May 2016 showed that staff used restraint 22 times across the three wards in the month. Staff used the face down prone position once for a patient on Kingston ward. During this month staff used rapid tranquilisation 12 times across the three wards. Rapid tranquilisation is when staff give medicines to a person who is very agitated or aggressive to calm them and reduce risk to themselves or others. Records showed these rates were reflective of the previous months as well. In the four months before inspection, staff used seclusion under ten times a month across the wards.

- Staff reported safeguarding incidents to a weekly safeguarding meeting, the local authority and the Care Quality Commission. Senior staff at the hospital attended the weekly safeguarding meeting. The local authority were invited to attend these every three months. Staff would also discuss inappropriate placements in this meeting. Records showed that staff supported patients to report incidents to the police if they wished.
- A pharmacist attended the service regularly and carried out monthly audits of medicines management. This included monitoring prescribing errors and administration errors. Each error was recorded on an online system that allowed communication of actions between the pharmacy and the service. Between January 2016 and April 2016 this audit showed that Kingston ward had no errors shown for January and February and under 1% of errors in March and April 2016. The most errors were shown to be on Upper Richmond ward, with prescription errors in March 2016 being just over 2.5% of all prescriptions for that month. The results from the audits were discussed by staff at ward level clinical improvement groups and reasons explored.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to identify and report incidents. In addition, each ward kept a written record of debriefs that took place after an incident, using a post incident debriefing form. We looked at a sample of these from Kingston ward. The level of detail that staff completed this in varied. There was not a high level of detail or analysis of how staff could learn from incidents to prevent them from occurring again or learn a particular patient's triggers for challenging or aggressive behaviour. Information about incidents and lessons learnt was included in clinical improvement group meetings that ward staff could attend.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- Records showed that each patient had one or more care plans recorded in their electronic notes. These related to their different needs, such as mental health and wellbeing, physical health and medication. At the last inspection in July 2015 we found that care plans for patients on Kingston ward were personalised and recovery orientated. They had details of the specific needs of a patient and patient risks were addressed in care plans. We reviewed two care plans in this inspection and found care plans were detailed, personalised and holistic.
- At the last inspection we found that care plans on Upper Richmond ward were not personalised and that patient needs were recorded as their diagnosis or the behaviour. During this inspection we found that three of six patients' care plans on Upper Richmond ward were personalised and detailed, but three were not. Those that were personalised covered the patient's specific circumstances in a lot of detail. For one patient who did not have detailed and personalised information recorded in their care plans, their health and wellbeing care plan referred to another patient in one sentence. For one patient where staff had assessed a risk as being poor dietary intake, there was no care plan in relation to this and no evidence that this was being monitored by staff. We also found that staff still recorded patient need with details of a patient's diagnosis, their behaviour, or which section of the Mental Health Act they were detained under. The recording of patient need had not improved on Upper Richmond ward since the last inspection. Patient needs were not clearly recorded elsewhere in patient records.
- Some patients were prescribed 'as required' medicines. During the last inspection in July 2015 we found that on

Upper Richmond ward, staff did not always clearly record the occasion and reason for a medication being given in clinical notes. During this inspection we found that staff consistently recorded when medicines were given in clinical notes. This was an improvement from the previous inspection. However, for two of six patients, the reasons for this were not written clearly on clinical notes, although they were detailed on the medicine administration charts. For this patient, on two of three occasions when patients required these medicines, staff noted the reason as "as per prescription", or not at all. For the third occasion staff had documented a reason in their clinical notes. This showed an inconsistency in recording of the reason as required medicines were administered. One patient had an 'as required' medicines care plan. An intervention detail on this care plan stated that staff should document reasons for giving the medicine. For a second patient, staff recorded information about their as required medication in the section about mental health medications. This was the incorrect place for it to be recorded and the dosage and specific medication was not outlined. This showed poor completion of clinical records.

- Following the inspection in July 2015 the service developed an action plan to address issues around the documentation of administering as required medications. This involved auditing care notes and discussing the results with ward staff and reporting this in senior staff meetings. The service provided an audit from one week in November 2015, nine months before this inspection took place. This audit was for six patient notes. It asked whether the occurrence of administering as required medicines was documented in care notes and whether the reason was documented. It did not ask where this reason was recorded. The audit showed that the reasons were recorded for all patients. It also showed that for 93 occurrences across the six patients, staff recorded this in care notes 42 times (45%). This meant that the auditing system in place had not been effective in identifying areas of concern.

Involvement in care planning

- At the last inspection in July 2015 we found that care records on Upper Richmond ward did not show evidence of patient involvement. During this inspection we found that some record evidence patient involvement, but was not consistent in all records. In three of six care records showed evidence that staff involved patients in their care as much as possible and recorded this. For these three patients, there was evidence that they were present and involved in meetings, discussions and decisions about their care. Staff recorded patient comments and views and patients signed their records. The information recorded was patient friendly and not overly clinical. Minutes from ward clinical improvement groups showed staff were encouraged and reminded not to use clinical abbreviations in their notes so they could be understood by patients. For one of these patients there was also evidence that they were involved in discussing triggers during their risk assessment and management plan. For three of six patients there was no or little evidence that they were involved in their care planning where possible. For example, for one patient their health and wellbeing care plan and detention care plan were written at 3.55am. In the identified needs section of the care plans, the staff noted that the patient was asleep at the time of the care plan being written and this would be discussed with them during the day. There was no evidence in the patient's progress notes that this took place. This shows that the care plan was written by staff with no involvement from the patient or attempt to involve them. Patients we spoke with on Upper Richmond ward were not aware of their care plans and did not have a copy of them.

- The electronic care system had a space to record patient comments. This was not filled in consistently by staff, including noting where patients were unable or unwilling to engage. For the three patients where this was completed accurately across their different care plans, staff had recorded patient views and comments in the patient's words. For other patients this was left blank or filled in inappropriately. For example, for one patient the reader was directed to another section of the document which was a list of patient presentation written by staff in clinical language. For another patient staff had recorded the patient views as "no capacity". There was no record of if and when staff had completed a capacity assessment to arrive at this judgement. For one patient staff noted that they may require an interpreter for conversations with staff. After this was noted there was no record of this being reconsidered or acted upon in a ten day period, up until the day of inspection. This patient was invited to meetings with

staff to discuss their care and was recorded as being present and engaged. However, at some points staff noted that their engagement consisted of the patient nodding their head to everything the staff said. This showed that the patient was not supported as well as they could have been in involving them in their care. It also showed that staff were recording a patient as being present and engaged, when the narrative in their notes showed this was not the case.

- In the last inspection, across the other wards we found that care records and feedback from patients indicated they were involved in their care. In this inspection we found the same. Patients we spoke with on Lower Richmond ward said staff went through their care plans with them in detail on paper and they discussed them together. One patient said staff went through their care plan, but they would like more detailed conversations and information about their medications. Care records on Kingston ward showed evidence of patient involvement. For example records of conversations and views of the patient were present and staff noted that the care plan was printed and discussed with the patient.
- Following the last inspection the service developed an action plan to address identified issues on Upper Richmond ward. Actions to address the personalisation of care plans, and also patient involvement, included nursing staff receiving training in care planning and staff carrying out audits of care plans. The audit tool consisted of 19 questions about the care plan and was used with a sample of two records from each ward. One question asked whether notes "demonstrated patient, staff, carer, guardian or parents etc." involvement. This did not separate whether notes demonstrated the involvement of patients as well as staff, which could have been more clearly measured. The most recent audit took place four months before this inspection. This audit showed compliance for two patients' notes on Kingston ward was 85% or over. Compliance on the other two wards was much lower, between 19% and 44%. The audit stated the lack of evidence of patient involvement and review of care plan were mainly responsible for the low scores. There were two recommended actions, one of which was to hold a care planning workshop for staff. This indicated that this had not yet taken place following the previous inspection nine months earlier.

Skilled staff to deliver care

- The service had a multidisciplinary team that included nurses, doctors, occupational therapists and social workers. There was one qualified occupational therapist and three assistant occupational therapists that worked across the three wards. Approval for a second occupational therapist post and an activities coordinator post had recently been secured.
- In our last inspection in July 2015 we found that on Upper Richmond ward, supervision was provided less frequently than on the other two wards. For example eight nursing staff had received supervision two times in the six months before the inspection. In this inspection we found that this had improved. In six of seven months before the inspection, between 90% and 100% of nursing staff received supervision every eight weeks on Upper Richmond ward. The provider's policy outlined the need for nursing staff to receive supervision a minimum of every eight weeks, in line with Nursing and Midwifery Council guidance. Supervision rates for non-nursing staff, for example occupational therapists and ward doctors was not being recorded as taking place each month. For ward doctors, this should have taken place each week.
- Staff new to the service, including agency staff, received an induction to the service and ward they were working on. New permanent staff worked on the ward for one week before they were counted into the staffing numbers.
- The organisation delivered a nurse leadership programme to enhance nursing staff clinical and managerial skills. Three staff from the service had been involved in this.
- Meeting minutes showed that staff reported when educational seminars were available. Minutes from Upper Richmond ward in May 2016 indicated that these were not available at the moment due to a shortage in staff.
- An advocate visited the wards three time a week. They wrote a monthly report for senior staff about their activity and engagement with patients. The advocate met with the deputy hospital director every two weeks to address any issues arising from patients. The advocate also supported patients to complete an annual patient feedback survey and ran a monthly

patient forum. We spoke with the advocate who felt the hospital welcomed their services and were cooperative and transparent. The advocate was always provided with a private space away from the staff to meet with patients. Staff from the wards and the advocate took into account that patients did not stay at the service for a long period of time, so worked to resolve patients' concerns as quickly as possible.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good governance

- At the last inspection in July 2015 there had been a recent period of significant transition in management. At this inspection there was a newly appointed hospital director who was supported by a deputy hospital director. The senior management team for the site attended regular meetings.
- Senior staff attended a monthly clinical governance meeting and produced monthly clinical governance reports. This included information about newly appointed staff and feedback from external organisation, for example the CQC and the local authority. This also covered a patient safety risk report and outlined actions taken in response to site incidents. Recruitment of qualified staff nurses was on this risk report. There was also space for lessons learnt to be presented in the meeting. Minutes from a May 2016 meeting showed staff presented four incidents and their lessons learned.
- Ward staff also held monthly clinical improvement groups. These covered ward incidents, bed numbers, results from audits and training needs. A patient representative attended these meetings to provide feedback from patients. There was evidence in meeting minutes that issues brought to the meeting by patients were considered and discussed as a group.
- There was a risk management committee for the three wards and a monthly research and audit meeting. Minutes from the meeting two months before the inspection showed ten audits were presented and discussed. The hospital had an audit schedule for the year.

Leadership, morale and staff engagement

- Sickness rates for permanent staff across the seven months before the inspection was 6.4%. This was an increase from the 12 months previous, where the average sickness rate was 3.9% with the highest rate of 6.2% in the month of November.
- Staff we spoke with said the teams worked together well, including receiving support from managers when necessary. Several staff said they enjoyed their jobs as it was rewarding.
- On Kingston ward staff were positive about their role and said they worked in a strong team that worked well. They felt managers were supportive and approachable and that issues raised on the ward were addressed. Some staff said morale had improved since the new hospital manager had been in place, which was four months.

Commitment to quality improvement and innovation

- The service was seeking accreditation with the National Association of Psychiatric Intensive Care Units and Royal College of Psychiatrists joint scheme for psychiatric intensive care units. Through this, staff were able to access national standards of care for psychiatric intensive care units.

- On Kingston ward staff were positive about their role and said they worked in a strong team that worked well. They felt managers were supportive and approachable and that issues raised on the ward were addressed. Some staff said morale had improved since the new hospital manager had been in place, which was four months.

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Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff are up to date with mandatory training requirements to ensure they are competent to provide safe and effective care and treatment.
- The provider must ensure all patient care plans on Upper Richmond ward are personalised and accurately reflect the individual needs and preferences of patients. Patients must be involved in developing their own care plan. Where this is not possible, staff must record the reasons in clinical notes.
- The provider must ensure all areas are cleaned effectively and regularly and records of this are up to date.

Action the provider SHOULD take to improve

- The provider should ensure that where a risk assessment score changes, the reason for this is recorded in patient notes.
- The provider should ensure they continue with their recruitment programme for permanent staff to reduce reliance on agency staff.
- The provider should ensure that staff record the reasons for 'as required' medicines being administered in clinical notes.
- The provider should ensure that where action plans are detailed in patient notes, these include dates for completion and who is responsible for auctioning this.
- The provider should ensure debriefing forms are completed in full to ensure learning from incidents takes place effectively and staff are supported.
- The provider should ensure where audits identify a need for improvement, a clear plan in put in place to address this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not provided care and treatment that was appropriate and the needs of the patients. On Richmond ward, there was inconsistency in care plans being individualised or personalised. There was limited evidence of patient involvement or collaboration in care plans for all patients. This was a breach of regulation 9 (1)(b)(c)(3)(a)(b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured all premises were clean. This was a breach of regulation 15(1)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured that there were suitably qualified, competent, skilled and experienced persons delayed to meet the needs of the patients. Mandatory training for permanent staff remained low in eight areas including safeguarding vulnerable adults, Mental Capacity Act 2005, information governance, fire safety, child protection, teamwork, breakaway and intermediate life support. This was a breach of regulation 18 (1)(2)(a)