Raphael Healthcare Limited (The Farndon Unit)

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

- On ward A, the ensuite bathrooms were dirty and in need of refurbishment.
- On-going staffing issues affected the hospital's ability to meet patients' needs, especially around access to leave and activities.
- Six out of 11 patients we spoke with told us that access to activities, including the resource room and gym, was limited due to the number of staff available. One patient told us they had only been able to access the resource room twice and could never use the gym.
- The hospital had experienced difficulties recruiting staff but it had an active recruitment plan. The hospital used a high number of agency and bank staff.
- Staff did not always give emergency alarms a timely and appropriate response, which put patients and staff at risk.
- Care plans did not show clear involvement of the patients and were not personalised. We found care plans that staff had not re-written since 2013 and 2014. We identified this issue on our last inspection, but the service had not addressed it.

Summary of findings

- We found areas of concern around practices relating to the implementation of the Mental Health Act.
- Medication was authorised at high doses up to 150% and 200% of British National Formulary limits on authorisation forms. The responsible clinician (RC) had not prescribed medication at these levels on all medicine charts.

However,

- No staff had worked for a continuous 24-hour period. This had been an issue at the last inspection.
- The hospital had introduced a staffing assurance tool to try to manage staffing issues.
- The hospital had reviewed and updated its policies and procedures following two serious incidents.
- The hospital had developed an audit to assess emergency responses. As this was very new, outcomes of the audit were not yet available.
- Staff completed physical health checks in line with national guidance. We found that patients received a physical health check on admission and annually thereafter.
- We observed positive interactions between staff and patients during our visit.
- Patients told us that the staff were approachable, good and caring.

Summary of findings

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Summary of this inspection

Background to Raphael Healthcare Limited (The Farndon Unit)

The Farndon Unit is a purpose-built independent sector hospital on the outskirts of Newark, Nottinghamshire. The Farndon Unit provides low secure treatment, care, and rehabilitation for women over 18 who are detained under the Mental Health Act. Some patients may also be subject to Ministry of Justice restrictions. Patients at the unit may have a diagnosis of mental illness and/or personality disorder, and some patients may have a mild to moderate learning disability with a co-existing mental illness or personality disorder. The unit has 46 beds on five wards – ward A, ward B, ward C, ward D and a rehabilitation/recovery ward.

The registered manager is Anne Armitage.

We last inspected the Farndon Unit 13 – 15 May and 5 June 2015. We rated Raphael Healthcare Ltd, the Farndon Unit as good overall.

However, there were actions identified that the provider must take to improve. There had been a number of occasions when the unit was short staffed, which meant that some staff had worked 24 hour shifts. This put both staff and patients at risk. This was a breach of Regulation 18.

Additionally, we told the provider it should ensure that care plans and risk assessments were regularly updated and that staff had an understanding of Deprivation of Liberty Safeguards.

Our inspection team

Team leader: Lynne Pulley, Inspector Care Quality Commission

The team that inspected the service comprised two CQC inspectors and a variety of specialists advisors:

- a consultant psychiatrist,
- a Mental Health Act reviewer
- an Expert by Experience (someone who has personal experience of using or caring for someone who uses mental health services).

Why we carried out this inspection

We carried out this inspection to see if areas of non-compliance we identified at the last inspection had been met. We also inspected to review actions taken by the hospital following a recent serious incident.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information.

During the inspection visit, the inspection team:

- visited all five ward areas and looked at the quality of the environment
- observed how staff were caring for patients
- spoke with 11 patients

Summary of this inspection

- spoke with the director of secure services and the clinical nurse manager
- spoke to 18 staff members, including ward managers and nurses of various grades, a consultant psychiatrist, student nurses, and a bank member of staff.
- observed two patient activities taking place
- looked at four sets of patient case records
- looked at 14 prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us ward staff were approachable, good and they cared. One patient said that her admission was meaningful. Two patients told us they did not like the food. Six patients told us that staffing levels negatively influenced activities they could complete. One patient told us that staff were slow in responding to an alarm, which allowed her to bang her head as a form of self-harm.

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?

- On ward A, the ensuite bathrooms were dirty and in need of refurbishment.
- Low staffing levels sometimes meant that staff cancelled patient leave and activities.
- Staffing levels had occasionally fallen below agreed levels but not below baseline staffing levels.
- The hospital had experienced difficulties recruiting staff, but it had an active recruitment plan. There was a high use of agency and bank staff.
- Emergency alarms did not always receive a timely and sufficient response, which continued to put patients and staff at risk.
- One patient told us that staff were slow in responding to an alarm, which had not prevented her from banging her head as a form of self-harm.

However,

- No staff worked continuously throughout a 24-hour period.
- The hospital had introduced a staffing assurance tool to try to manage staffing issues.
- The hospital had reviewed and updated its policies and procedures following a recent serious incident.
- The hospital had developed an audit to assess emergency responses. As this was very new, outcomes of the audit were not yet available.

Are services effective?

- Care plans did not show clear involvement of the patients and were not personalised.
- Staff had not re-written two care plans since 2013 and 2014. This was something we identified on our last inspection. The hospital had not addressed it.
- We found areas of concern around practices relating to the implementation of the Mental Health Act. This related to patients accessing reviews for section 17 leave and patients receiving assessments prior to detentions lapsing.

Summary of this inspection

- Medication was authorised at high doses 150% and 200% of British National Formulary limits on authorisation forms. The doctors had not prescribed these high levels of medication on all medicine charts but the high doses of medication authorised concerned us.

However,

- Staff completed physical health checks on patients, both on admission and annually thereafter.
- Bank staff received the same mandatory training as regular staff. This meant bank staff had sufficient training to complete their roles.
- An individual weekly programme of activities was available to patients.
- We observed positive interactions between staff and patients during the inspection.

Are services caring?

- Patients told us the staff were approachable, good and they cared.
- We observed warm, relaxed interactions with patients and staff members. We saw that staff were interacting with patients in a friendly manner during group activities.
- One patient said that her admission was meaningful and she had progressed whilst at the hospital. She also said that the psychology team were good.

Are services responsive?

- Six patients of the 11 we spoke with told us that access to activities, including the resource room and gym was limited due to the numbers of staff available. One patient said they had only been able to access the resource room twice and never managed to get to use the gym since moving to the hospital.

Are services well-led?

- Ward staff reported varying confidence in the senior staff team. Staff told us they would feel confident to raise concerns, good leadership was present, and the service was reasonable and accommodating. One staff member told us senior staff imposed changes that were not practical to put into practice.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The responsible clinician on A ward worked one day each week. No arrangements were in place to ensure care and treatment was reviewed when the responsible clinician was not available. For example, one patient reported that Section 17 leave had not been reviewed for a month due to the responsible clinician's annual leave.
- Section 17 leave was authorised by the responsible clinician on standardised forms. The responsible clinicians' had granted all patients Section 17 for physical healthcare appointments. They had specified conditions. This meant that if patients became unwell they could leave the hospital to access physical healthcare.
- We did not find consistent evidence that the hospital reviewed episodes of leave with the patients. Following patients taking leave, it is expected within the Code of Practice that the hospital reviews how the leave went and records this in patient notes to inform future decision-making.
- The Ministry of Justice had recalled a patient from a conditional discharge. There was no evidence in the notes that the responsible clinician had assessed her capacity prior to commencing treatment under the three-month rule, this should have happened.
- We did not find evidence in patient notes that the responsible clinician had informed a patient they were being treating on the authority of a T3 (this is a treatment certificate for patients who do not consent). Nor was there recording of the outcome of a visit by the second opinion approved doctor (SOAD). The responsible clinician should have explained to the patient what the SOAD had reported.
- The hospital allowed the detention of one patient to lapse. She had subsequently been detained under Section 5.2 and then under Section 3 of the MHA. The hospital should have arranged for the patient to be reviewed prior to her detention lapsing.
- There was evidence of manager's hearings and tribunals taking place. This meant that patients were exercising their rights to appeal.
- There was evidence of staff giving patients information about their rights in accordance with Section 132. Staff recorded this on standardised forms. However, these were not always fully completed. In one casefile, there was no record if the patient understood their rights. On another case file, staff had not completed the section relating to the patient agreeing or disagreeing to staff giving information to their nearest relative.
- There were no copies of original detention papers on some case notes. Staff obtained the necessary paperwork from the MHA administrator during our visit.

Forensic inpatient/secure wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

- On ward A en-suite bathrooms were dirty and badly in need of refurbishment. One washbasin had small flies emerging from the drain. The director of secure services and ward manager agreed with our view. They agreed to develop systems to monitor the cleaning of bathrooms, and to ensure necessary refurbishment was undertaken.
- On the rehabilitation and recovery ward, one patient told us that they could not shower properly since the hospital removed the curtains. The hospital removed the curtains due to a potential ligature risk. People passing on the main road could see the patient. We pointed this out to the director of secure services. The hospital applied a substantive film to the window when we were there.
- The acoustics in the de-escalation room on ward A were poor, with noise from the day room bouncing around the room. One patient told us how stressful she found this. The director of secure services and ward manager agreed to order sound absorbing panels. The room was empty. The hospital had ordered a new sofa as the old one had been broken.

Safe staffing

- The hospital operated two main shifts. Days were from 7.30am until 9.00pm, nights were from 8.45pm until 7.45am. Additional shifts were early shifts 7.30pm until 4.30pm and late shifts 1.00pm until 9.00pm.
- The hospital had identified a baseline staffing level of 15 staff across the five ward areas. This was the minimum staffing level the hospital would operate. However, the hospital had identified a higher staffing level, which it aimed to meet. This consisted of 21 staff on days and 19 staff on nights, the hospital referred to this as its agreed staffing level. Each ward required at least one qualified nurse to be on shift at all times.
- At the time of inspection, the hospital had 30 qualified nurse posts with 23.66 qualified staff in post. The hospital employed three locum nurses to help fill the shortfall. One preceptorship nurse was due to start in April 2016. The establishment for care assistants was 75 staff. There were 67 staff in post. There was one qualified nurse and one care assistant on maternity leave that the hospital had not accounted for in the number of staff in post. There was one vacancy for an activities co-ordinator.
- We reviewed the duty sheets for the previous two weeks in detail. During this period, no staff had worked continuously over a 24-hour period. At our last inspection, staff had worked continuously over a 24-hour period. The hospital had addressed this action.
- In the previous two weeks, we found on eight occasions the hospital staffing levels fell below their agreed numbers, but not below the baseline staffing numbers. The service had unexpected sickness and cancellation of planned shifts which affected this.
- During a weekend, the first on-call manager attended the hospital on both Saturday and Sunday. The on-call manager worked on Saturday from 1.20pm until 7.00pm on ward B to maintain staffing levels. On Sunday, the same on call manager worked from 10.30am until 5.45pm on the recovery ward and then worked from 11.30pm until 6.20am on ward D. This meant that the on-call manager worked in excess of twelve hours, over the day and night on the Sunday/ Monday with a break of 5 hours 45 minutes in-between the two periods.
- The hospital used agency staff, bank staff, and locum staff on a daily basis to meet staffing levels. Duty rotas

indicated that agency staff use varied from two staff per shift up to nine staff per shift. On two separate occasions, qualified agency staff covered four shifts over the 24-hour period.

- The service mitigated staff shortfalls on other occasions by ward managers (who were supernumerary) becoming part of the ward staffing establishments. Staff stayed on shift after their allocated time or came in early before their allocated time to cover shortfalls. The hospital also used on–call managers to cover deficits in staffing the wards.
- From October until December 2015, the use of agency and bank staff continually exceeded the 5% target commissioners set for the hospital on all but one occasion.
- The hospital had an active recruitment plan to recruit new staff. The director of secure services told us that they had successfully recruited many new staff. We saw a large group of new staff arriving for their induction at the beginning of our visit.
- The hospital introduced a daily staffing assurance tool. This tool helped senior staff ensure sufficient staffing was available to meet patient needs. The tool looked at staff shortages, skill mix, female cover (10 female staff identified as a minimum), clinical activity/ changes and leave requirements across the hospital. We saw evidence that the hospital was using the tool and making changes to staff deployment to meet patient need.
- On the day of inspection, the hospital met agreed staffing levels, although some staff were borrowed from other ward areas to meet patient need. Four staff members told us the hospital regularly 'borrowed' staff from other wards to cover staff deficits.
- Five staff members told us that the hospital staffing establishment did not take account of patient leave. Two staff told us staff numbers reduced if staff were required to facilitate driving patients on leave. Staff said staffing numbers were often low when patients took leave from the hospital. We were told shifts started fully staffed but dropped if escorts were needed. Four staff members said having sufficient staff was an on-going problem. We were advised by staff that the week prior to our visit staffing had been an issue on ward A as two patients were in a general hospital and required escorts continually.
- Two staff members said the hospital sometimes cancelled patient leave due to poor staffing levels. Two other staff members said the hospital needed extra staff to facilitate regular café access for patients and patient outings. One patient told us, since an activity co-ordinator left, it had been difficult for patients to access the resource centre. Ward A had been without an activity co-ordinator for some weeks so the ward manager had used the vacancy budget to buy in additional care worker hours to facilitate activities on this ward.
- The hospital allocated one person from each ward to respond to alarms. Staff told us the allocated staff member might have gone out with patients for leave. One patient told us that during an incident she banged her head as a form of self-harm, as only three staff were available to support her. The hospital had not ensured that staff responded to emergency alarms in a timely manner. We identified this at our last inspection.
- Staff reported in response to emergency alarms there was usually a good response, with at least two staff responding. Two staff members told us of recent incidents where staff activated emergency alarms to summon assistance and only one member of staff responded. On one occasion there was another incident occurring in the hospital at the same time. The previous week a staff member had left work to seek medical review after being injured in an incident.
- Four staff told us that at least weekly, they did not get breaks while on duty due to staffing shortages or incidents. One staff member told us that recently this had improved and they were now getting regular breaks. Staff were not always getting regular breaks during their shifts on duty and may have become tired.
- One bank member of staff told us they completed shifts at the hospital at least every week for the past four years.
- Staff turnover for the previous nine months was broken down into quarters (three-month periods). In the previous three months, 0.5% of qualified staff had left. The six months prior to this, there were no changes. Care assistant figures over the nine months, broken down into quarters, were 0.5%, 1.5%, and 2.5%. These figures were not high.
- Sickness levels were broken down into quarters. Sickness levels were 3.4%, 3.9%, and 3.2% for the previous nine months. These are not high sickness levels.

Forensic inpatient/secure wards

Assessing and managing risk to patients and staff

- Records reviewed all contained a risk assessment. We saw evidence that staff updated these.
- The hospital applied some restrictions to all patients for safety reasons. For example, staff did not allow patient access to bedrooms whilst sharps were available at mealtimes. Staff individually assessed bedroom access for patients, but this was only at specific safe times.
- The hospital reviewed and changed its policies on observation and record keeping following an earlier incident. It made changes to the recording sheet to include the actual time of the observation and what the patient was doing at that time.
- Seven staff told us that they did not always feel safe or that support from colleagues was available when they needed it. For example, one staff member told us, if there were new staff on shift, they would not have confidence in those staff to support them if incidents occurred.
- One staff member told us they had been the only female member of staff on the ward for a shift and this left them physically and emotionally drained. No female patients raised issues with us about male staff members caring for them.

Track record on safety

- The hospital experienced one death and a serious incident between January 2015 and February 2016. The hospital made a number of changes as part of lessons learnt following the serious incident. For example, the hospital reviewed policies relating to the observation of patients and record keeping. They also reviewed their procedures for summoning external emergency assistance. We saw that the hospital's staff induction now included a section on the observation of patients.

Reporting incidents and learning from when things go wrong

- Staff told us they did not always attend post incident de-briefs due to low staffing numbers.
- The hospital had very recently introduced an emergency response audit. It had developed emergency scenarios and started to assess staff responses to these. Situations covered were; patients found with ligatures, choking on food, collapsed, barricaded in a room, or suffering from anaphylaxis. We saw that the audit detailed staff response times and staff numbers responding to the initial emergency alarm activation. The audit assessed the responses of staff members to the presenting scenario. As this was a very new initiative, the hospital could not provide us with figures and outcomes of this audit. The hospital planned to use the outcomes of the audits to develop further learning and improvements in practice.

Are forensic inpatient/secure wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Two care records we reviewed were very similar in their content and not personalised
- We found staff wrote two care plans we reviewed in 2013 and 2014. At our last inspection, we identified that the hospital should regularly review and update care plans and risk assessments. Staff had not fully rewritten care plans for up to three years.
- Only the nurses signed monthly reviews. We could not find evidence of staff involving patients in the writing or review of their care plans. Two care plans we checked did not contain patient signatures.
- One ward manager sent an email to qualified staff during our visit asking them to rewrite care plans with patients. This was so that patients were fully involved in their care planning, and plans reflected patient views and they linked to crisis plans. One patient told us she did not have a named nurse and was unaware of any care plans.
- Patients had regular physical healthcare checks. There were physical health care plans present. These did not all evidence patient involvement and some appeared generic not patient specific.
- One patient had a care plan for smoking cessation. National guidelines encourage smoking cessation.

Best practice in treatment and care

- Occupational therapy services were available Monday to Friday. Sometimes the hospital cancelled activities due to staffing levels or cut them short.
- Five patients on A ward had high dose medication authorised on Mental Health Act forms above British

National Formulary maximum limits, ranging from 150% -200% of recommended doses. However, the medical team had not always prescribed medication at these levels. We did not find reference to the consensus statement on high-dose antipsychotic medication CR190, issued by the Royal College of Psychiatrists.

- 'As required' medications did not contain a maximum dose, only the time intervals, within which the nurses could give the medication. This meant that the maximum amount of medication patients could receive over a 24-hour period was not clear.
- Patients did not feel the hospital always addressed their physical healthcare concerns and this worried them. One patient wished to make a complaint about the way the hospital had responded to her concerns about her physical health.

Skilled staff to deliver care

- The hospital had an active recruitment programme to try to recruit sufficient staff. We saw a large group of new staff attending for their induction as we arrived.
- Bank staff received the same mandatory training as permanent staff. The hospital supported one bank staff member we spoke with, to complete NVQ3 training in health and social care. They received time and funding to complete this. This meant that the hospital trained bank staff to complete their roles.
- Staff received an induction when they started at the hospital. We saw the induction was comprehensive and covered multiple areas.
- Staff members we spoke with confirmed receiving regular supervision and an annual appraisal. However, one staff member told us they had not completed a full supervision session due to incidents happening. We did not check the supervision records during our visit.
- The hospital employed five learning disability (LD) qualified nurses. All LD nurses completed their induction, mandatory training, and necessary refreshers. Three LD nurses completed additional training on positive and proactive care, the positive, behaviour support (PBS) model.

Adherence to the MHA and the MHA Code of Practice

- The responsible clinician on A ward worked one day each week. No arrangements were in place to ensure care and treatment was reviewed when the RC was not available. For example, one patient reported that Section 17 leave had not been reviewed for a month due to the responsible clinician's annual leave.
- Section 17 leave was authorised by the responsible clinician on standardised forms. All patients had been granted Section 17 for physical healthcare appointments, and the conditions were specified. This meant that if patients became unwell they could leave the hospital to access physical healthcare.
- The hospital introduced a new system to try to manage section 17 leave. All leave went through the leave co-ordinator who prioritised and planned patient leave across the hospital site. This was to try to ensure that leave happened and that staffing levels on all wards remained suitable.
- We did not find consistent evidence that the hospital reviewed episodes of leave with the patients. Following patients taking leave, it is expected as defined in the Code of Practice that the hospital reviews how the leave went and records this in patient notes to inform future decision-making.
- The Ministry of Justice had recalled a patient from a conditional discharge. There was no evidence in the notes that the responsible clinician had assessed her capacity prior to commencing treatment under the three-month rule, this should have happened.
- We did not find evidence in patient notes that the responsible clinician had informed a patient they were being treating on the authority of a T3 (this is a treatment certificate for patients who do not consent), nor recording of the outcome of a visit by the second opinion approved doctor (SOAD). The responsible clinician should have explained about the T3 and what the SOAD had reported.
- The hospital allowed the detention of one patient to lapse. She had subsequently been detained under Section 5.2 and then under Section 3 of the MHA. The hospital should have arranged for the patient to be reviewed prior to her detention lapsing.
- On D ward, all medicine cards checked had a capacity to consent to treatment form (T2) with them. This is a requirement for detained patients.
- On B ward, we reviewed five treatment cards. We found that medication was prescribed that was not detailed on the treatment authorisations (T2 forms). Two patients had medications prescribed, but the nurse

could not tell us if it was to treat physical health issues or mental health issues. This means that nurses were unclear under which legal authority they were administrating medication.

- There was evidence of manager's hearings and tribunals taking place. This meant that the hospital reviewed patients' detentions and patients were exercising their rights to appeal.
- There was evidence of staff giving patients information about their rights in accordance with Section 132. Staff recorded this on standardised forms. However, these were not always fully completed. In one casefile, there was no record if the patient understood their rights. On another case file, staff had not completed the section relating to the patient agreeing or disagreeing to staff giving information to their nearest relative.
- There were no copies of original detention papers on some case notes. Staff obtained the necessary paperwork from the MHA administrator during our visit.

Good practice in applying the MCA

We did not review the MCA as part of this inspection.

Are forensic inpatient/secure wards caring?

Kindness, dignity, respect and support

- Patients told us the staff were approachable, good, and they cared.
- We observed positive warm relaxed interactions with patients and staff members. We saw staff interacting with patients in a friendly manner during group activities.
- One patient said her admission was meaningful and she had progressed whilst at the hospital. She also said the psychology team had been good.
- Six patients told us access to activities, including access to the resource room and gym was limited due to the number of staffing available. One patient said they had only been able to access the resource room twice and never managed to get to use the gym since moving to the hospital.

Are forensic inpatient/secure wards responsive to people's needs? (for example, to feedback?)

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital was due to review its rule prohibiting patients receiving cooked foods from friends and families. This was to meet the cultural dietary preferences of some patients.
- An individual weekly programme of activities was available to patients. Throughout the visit staff and patients were engaging in activities such as pamper sessions, origami and colouring together.

Are forensic inpatient/secure wards well-led?

Leadership, morale and staff engagement

- Staff reported varying confidence in the senior staff team. Two staff told us they would feel confident to raise concerns and good leadership was present. Another staff member said the service was accommodating and reasonable and that they had never found a 'closed door' to management. One staff member told us senior staff imposed changes that were not practical to put into practice. They gave an example of a new observation chart the hospital introduced. Another staff member expressed a lack of confidence in senior managers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure the care environment is clean and properly maintained.
- The hospital must maintain staffing levels above baseline numbers to agreed staffing numbers at all times, to ensure patient safety.
- The hospital must ensure that emergency alarms are responded to by sufficient numbers of staff in a timely way.
- The hospital must ensure that they comply with the requirements in relation to the implementation of the Mental Health Act. It must ensure a responsible clinician is identified to review patients at all times. It must ensure that patients are reviewed prior to detentions lapsing.
- The hospital must ensure patient participation in care plans, and ensure they are personalised and reviewed.

Action the provider SHOULD take to improve

- The hospital should ensure that patients receive planned activities as part of their care and treatment.
- The hospital should continue with their recruitment plan to reduce the high use of bank and agency staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The en-suite bathroom on ward A was dirty and in need of refurbishment, this put patients at risk. This was a breach of regulation 15 (1) (a) (e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing levels were not maintained to agreed staffing numbers at all times, to ensure patients were safely cared for. Emergency alarms did not always receive a timely and sufficient response, which put patients and staff at risk. This was a breach of regulation 18 (1)

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 (RA) Regulations 2014 Person-centred care Care plans did not show clear involvement of the patients and were not personalised. Staff had not re-written care plans since 2013 and 2014. This was a breach of regulation 9 (1) (c)

This section is primarily information for the provider

Requirement notices

A patient's access to Section 17 leave was not reviewed for a month as their responsible clinician was on leave. The hospital had not made cover arrangements. A patient's detention under the Mental Health Act was allowed to lapse before the patient was re-assessed.

This was a breach of regulation 9 (3) (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.