Harriet Tubman House

Quality Report

Harriet Tubman House
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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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive?	Inadequate
Are services well-led?	Inadequate

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

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

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

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

Summary of findings

Overall summary

The CQC is placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.'

We rated Harriet Tubman House as inadequate because:

- The manager and operations director were not aware of the regulations that they needed to meet to ensure a safe service for patients.
- The hospital did not have effective procedures to ensure the safety of patients and staff and to mitigate any risks to them.
- Staff did not identify risks to patients' safety and take action to reduce them.
- Staff did not analyse incidents of harm or risk of harm so they could not identify trends and learn from them to prevent them happening again.
- Care plans and risk assessments did not show staff how to support patients.
- Staff did not demonstrate a good understanding of the Mental Health Act and Mental Capacity Act. This had resulted in inappropriate applications made to deprive patients of their liberty.
- Some staff did not engage with patients in a positive way to promote their wellbeing.
- The environment did not promote patients' recovery and ensure they were comfortable.
- The hospital had no governance structures to assess risks and the quality of the service to promote improvements.
- Builders were renovating the hospital at the time of our inspection and the managers of the service were not taking proper action to prevent avoidable risks to patients and staff. As a result of our concerns and those expressed by a Health and Safety Executive inspector, the provider suspended the work until patients could be moved to alternative accommodation.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Inadequate 	**We rated Harriet Tubman House as inadequate because:** • The manager and operations director were not aware of the regulations that they needed to meet to ensure a safe service for patients. • The hospital did not have effective procedures to ensure the safety of patients and staff and to mitigate any risks to them. • Staff did not identify risks to patients' safety and take action to reduce them. • Staff did not analyse incidents of harm or risk of harm so they could not identify trends and learn from them to prevent them happening again. • Care plans and risk assessments did not show staff how to support patients. • Staff did not demonstrate a good understanding of the Mental Health Act and Mental Capacity Act. This had resulted in inappropriate applications made to deprive patients of their liberty. • Some staff did not engage with patients in a positive way to promote their wellbeing. • The environment did not promote patients' recovery and ensure they were comfortable. • The hospital had no governance structures to assess risks and the quality of the service to promote improvements. • Builders were renovating the hospital at the time of our inspection and the managers of the service were not taking proper action to prevent avoidable risks to patients and staff. As a result of our concerns and those expressed by a Health and Safety Executive inspector, the provider suspended the work until patients could be moved to alternative accommodation.

Summary of findings

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Inadequate

Harriet Tubman House

Services we looked at :

Long stay / rehabilitation wards for working age adults

Summary of this inspection

Background to Harriet Tubman House

Harriet Tubman House is an independent hospital for up to 15 women with enduring mental illness. The hospital provides a rehabilitation service and patients who are detained under the Mental Health Act can be admitted. On the days of our latest inspections, there were nine patients using the service.

Harriet Tubman House is one location that is part of the registered provider Options for Care Limited which has another mental health hospital for men and a social care home for people with a learning disability. All three locations are in Birmingham.

Options for Care are a limited company and it is the company that is registered with CQC and not an individual. The provider employed an Operations Director to manage all three locations. A manager was employed at Harriet Tubman House and had made an application to register with CQC. There was previously one registered manager over the three locations that left the organisation in February 2015. The provider made a decision to employ a registered manager for each location with an Operations Director to oversee the management of all three.

The provider had agreed to a voluntary embargo on admissions following our inspection of their other hospital in June 2015. The last patient admitted arrived in January 2015.

Harriet Tubman House was registered with the CQC from 1 October 2010. We inspected it on 8 October 2012 and took compliance actions in respect of management of medicines and records. We inspected again on 8 April 2013. The provider had rectified the previous breaches of regulations but we made compliance actions in respect of care and welfare, and assessing and monitoring the quality of service provision. We inspected again on 12 September 2013 and found that the provider now complied with the regulations. On 8 October 2014, we inspected the hospital again and made compliance actions in respect of consent to care and treatment and again for assessing and monitoring the quality of service provision.

Our inspection team

The team comprised three CQC inspectors including the team leader Sarah Bennett, a specialist advisor who was a nurse, an expert by experience and a Mental Health Act reviewer on 10 August 2015.

On 13 August 2015 the team leader and another CQC inspector inspected.

On 17 August 2015 the team leader, another CQC inspector and an inspector from the Health and Safety Executive inspected.

On 30 September 2015 a pharmacist inspector visited to inspect the medicine management processes and systems.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme on 10 August 2015. We inspected again on 13 August to speak with the night staff about concerns raised regarding scaffolding checks. Due to health and safety concerns identified, we visited again with the Health and Safety Executive inspector on 17 August. A pharmacist inspector visited on 30 September 2015.

Summary of this inspection

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 Harriet Tubman House and asked other organisations for information.

During the inspection visits, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with the manager
- spoke with the chief executive
- spoke with the operations director
- Spoke with 12 other staff members; including support workers, doctors, nurses and occupational therapist.
- attended and observed one hand-over meeting
- looked at nine patient treatment records
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the management of the service

What people who use the service say

- Patients told us they liked the food and there was plenty of it.
- Two patients told us that the refurbishment works were taking too long, which meant that their belongings were stored in bags and cases.
- Patients said the staff were okay and not abusive.
- Patients knew how to make a complaint. One patient said they had no need to complain, as they were happy there. Another was not confident that staff would listen to their complaints.
- Patients told us that an advocate visited often and they knew how to contact them if they needed to.

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?

Inadequate

We rated safe as inadequate because:

- The building was being renovated at the time of our inspection. The work did not comply with health and safety regulations and the provider had not taken appropriate action to mitigate risks to patients and staff. The provider decided to suspend the building work following our concerns and those of the Health and Safety Executive inspector.
- Some parts of the building were unsafe and the risks of this had not been reduced.
- Environmental risk assessments were not undertaken regularly.
- There were four vacancies for registered nurses out of the establishment of eight. Agency and bank nurses covered these vacancies and staff sickness. Agency staff did not receive a comprehensive induction to ensure they knew how to keep patients safe. This meant that patients sometimes did not get the treatment they needed, for example, timely pain relief.
- Risk assessment did not detail how staff were to support the patient and ensure their safety.
- Risk assessments were not completed before a patient went on section 17 leave (which is leave granted to patients detained under the Mental Health Act). Blanket mandatory conditions were on all patients' section 17 leave forms regarding medication and compliance with care plans. Conditions are meant to be applied individually as appropriate.
- Staff had not received training in breakaway or de-escalation techniques. This had resulted in incidents where staff had restrained a patient, which might not have been necessary if they had been properly trained.
- Records showed that restraint was used but this was not done in line with any guidance from the provider. Staff had not received training in the use of restraint.
- Staff had limited knowledge of safeguarding patients from abuse and the procedures to be followed.
- Medicines and medical equipment were not managed in a safe way for patients and action was not taken to mitigate identified risks.
- The hospital had no procedures on keeping visiting children safe.
- Staff did not recognise concerns, incidents or near misses. Some staff were not aware of incident reporting procedures.

Summary of this inspection

- There was no evidence of change made as a result of feedback from incidents.

However:

- At a previous inspection at the provider's other hospital, we identified that the medicine management systems needed to improve to meet the regulations. In response to this, a pharmacy had been contracted at both hospitals to oversee the medicines management systems. We saw that safe systems were in place to ensure that patients received their prescribed medicines on time.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Care plans did not identify how staff were to support patients to meet their needs.
- Care plans were not person centred and did not focus on the rehabilitation of the patient.
- There was very limited monitoring of people's outcomes of care and treatment.
- Staff told us that psychological therapies recommended by the National Institute for Health and Care Excellence were not offered to patients.
- Staff did not have the training and managerial supervision necessary to give them the skills to deliver effective care and treatment.
- Some patients' Mental Health Act records were not in good order to assure their rights under the law.
- Patients who were not detained under the MHA were not free to leave when they wanted to. The staff failed to recognise that these patients were being deprived of their liberty with no legal safeguards.
- Applications to authorise a deprivation of liberty were not made in accordance with the Mental Capacity Act 2005

However:

- Most patients' records showed that they had yearly physical health checks.
- An occupational therapist, psychologist and psychiatrist had been employed and worked together as a multidisciplinary team.
- There were effective handovers between each shift.
- Patients' records showed that detained patients were informed of their rights under the Mental Health Act and had access to advocacy services.

Summary of this inspection

Are services caring?

Inadequate 

We rated caring as inadequate because:

- We observed that staff did not always respect patients' privacy and dignity. For example, staff told us that a patient was 'aggressive' in front of them. This did not respect the patient's privacy or dignity and the patient looked upset by this comment made to a visitor. We observed a staff member stood in the lounge with their arms folded watching patients but they made no attempt to engage with them. This showed no respect for the privacy of the patients who were sitting in the lounge.
- Patients were not involved in their care planning.
- Staff did not always follow patients' care plans, which affected their privacy and dignity.
- One patient's continence needs were not met which impacted on their dignity.

However:

- Patients had access to advocacy services.

Are services responsive?

Inadequate 

We rated responsive as inadequate because:

- The hospital was for rehabilitation of patients but there was no evidence of discharge planning in any of the patients' care plans. One patient had lived there for 15 years and other patients had been there for several years each.
- Psychological therapies were not offered to patients to promote their recovery.
- The environment did not promote patients' recovery and that ensure they were comfortable
- The environment during the refurbishment works did not promote patients' privacy and dignity.
- A visitors' room was not provided and visiting arrangements for children did not ensure their safety.
- Activities offered to patients were limited and did not promote their independence.
- The hospital had no complaints processes so patients could not be confident that their views would be listened to and action taken to make improvements.

However:

- An occupational therapist and activity worker had been employed and had started to plan activities to meet patients' needs.

Summary of this inspection

- Patients told us they liked the food and that it met their cultural and religious needs.
- Patients had access to spiritual support.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- There was no statement of the vision and values of the organisation.
- Some policies and procedures were out of date and referred to previous legislation.
- There were no governance structures in place. This meant that there were no mechanisms for monitoring risk, safety or quality of care delivered.
- The manager and operations director were not aware of the regulations that they needed to meet to ensure a safe, effective, caring, responsive and well-led service for patients.

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.

- Eight of the nine patients were detained there under the MHA. We looked at four detained patients files.
- Four staff told us they had recently received training in the MHA and training records confirmed this.
- All treatment was given under an appropriate legal authority. We saw specific capacity assessments pertaining to treatment.
- The consent to treatment forms were kept with the medication charts. However, in one file we saw the current form and a previous T3 were both attached to the medication chart, which could cause confusion to staff giving medication. This was highlighted to the Responsible Clinician on the day and the old form was removed.
- In three out of the four files, the detention papers were not fully available and were incomplete. Approved Mental Health Professional reports were not available in these files.
- We saw evidence in files of patients being made aware of their rights. However, we were unable to see evidence of a discussion about rights on detention. The reason was that some of the patients had been there for several years so their records were archived. We saw that further attempts to explain rights were made to patients. Information was provided in an appropriate and accessible format and was displayed on the notice board.
- The MHA administrator had been in post since 1 July 2015. They worked full time and were based at another hospital within the organisation. They had six years' experience in a NHS trust as a MHA administrator and had completed the training required for that role.
- The MHA administrator had recently completed an audit that covered treatment, leave, rights and advocacy. An action plan had been sent to the nurse in charge and the managers were copied in. However, we found that the actions required from this had not been implemented at the time of our inspection.
- There was evidence in the files that patients had been informed of the Independent Mental Health Advocacy service. They held a drop in session there once a month.
- We saw the Second Opinion Appointed Doctor's (SOAD) consultation with statutory consultees in the patients' files. However, we were unable to locate the Responsible Clinician's discussion with the patient in respect of the SOAD's decision.
- In one file, we were unable to locate a S61 review of treatment report. This requires that where a patient has received treatment certified by a second opinion appointed doctor, the approved clinician in charge of the patient's treatment must report on the treatment and the patient's condition to the CQC. These reports are required generally when a patient's detention is renewed following a second opinion or when the CQC requires one.
- A review of the leave forms showed that leave was authorised through a standardised system. This included the conditions of leave, the start and expiration date and type of leave. We saw that patients had signed leave forms and that staff had offered copies to all but one. Risk assessments before leave was authorised were unavailable and staff confirmed that these were not completed before leave was taken.
- We found on all of the leave forms there were blanket mandatory conditions regarding medication and compliance with care plans. The forms did not indicate whether the patient had the capacity to consent to the conditions or if they understood what was expected of them whilst out on leave.
- Old leave forms were scored through to avoid errors being made.
- There was evidence of tribunals and managers hearings taking place and we saw the reports of these.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Four staff told us they had recently received training in the MCA. Training records showed that eight staff had received this training. The MHA administrator also told us they had completed training in the MCA and DoLS.
- We looked at the file for the informal patient. Regular capacity assessments relating to the decision for the patient to stay there had been completed. The patient had fluctuating capacity and this was evident from the frequency of the capacity assessments.
- An application had been made to the local authority for a Deprivation of Liberty Safeguard (DoLS) for an informal patient. It was not clear in the records we looked at whether or not this had been authorised. The Responsible Clinician (RC) told us that it was. The RC also said the patient had capacity to make decisions so the DoLS should have been withdrawn. This was done when we identified this. Three members of staff spoken with told us that if the patient tried to leave they would try to stop them. The safeguards are to ensure that any restrictions on a patient's freedom are the minimum necessary. However, as the patient was not detained under the MHA this was being used to prevent them from leaving the hospital.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Notes

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

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

Inadequate

Safe and clean environment

- The layout did not allow staff to observe all areas. However, CCTV cameras had been installed in the lounge and communal areas. The nurse's office had been moved to the office overlooking the lounge to improve lines of sight.
- The building had fixtures and fittings that patients who were at risk of suicide could use as anchor points for a cord for the purpose of strangling or hanging themselves. The managers of the hospital had recognised this and this was one of the reasons that they were undertaking renovation works at the time of the inspection. The hospital manager told us that anti-ligature furniture and fittings would be installed in six bedrooms. The other bedrooms would be used for patients stepping down and therefore presented less of a risk of self-injurious behaviour. Blinds had been removed in some bedrooms to reduce ligature risks. Some areas could not be used and most patients had moved to other bedrooms during the refurbishment. Following our inspection, an external consultant visited to assess the environment and the ligature risks. We have since seen the report of this assessment.
- The building works had created some risks to patients that staff had not adequately mitigated. Following our inspections on 10 and 13 August, we liaised with the Health and Safety Executive (HSE). We carried out a joint inspection of the hospital with an HSE inspector on 14 August 2015. The HSE inspector found that the provider had contravened Construction (Design and Management) Regulations 2015 (CDM 2015) Regulations. Contractors had installed scaffolding at the front of the building for use during the refurbishment works. Prior to our inspections on 10 and 13 August, staff were required to make physical checks on the external of the building every 15 minutes. We raised concerns with the provider and operations director about the need for this and the safety of staff and patients during these checks. On 14 August, the provider had installed a sensor system that would activate an alarm within the building if unauthorised access to the scaffold had been gained by intruders. However, on the afternoon of 17 August, when we inspected again, managers had not told staff what to do if the alarm went off. The provider also informed us that to prevent unauthorised access onto the scaffolding they had ensured all ladders were removed from the scaffold when not in use. On 17 August, the scaffold was not in use but the ladder providing access was still in place. The rungs of the ladder were bent and the treads were worn. There was no footing to the ladder so it would be unsafe if a person tried to climb it. The HSE inspector asked for the ladder to be condemned with immediate effect. The providers' risk assessments did not contain information regarding the use of a ladder but had referred to the use of a mobile elevated work platform for the contractors to use to gain access when working at height. In the opinion of the HSE inspector, the provider had failed to take appropriate measures to ensure that the site was adequately secure and suitable measures were not

implemented to prevent unauthorised access on to the scaffolding. Following our inspections, the provider stopped the refurbishment work until the patients had been moved to alternative accommodation.

- We identified two other significant risks caused by the physical environment that staff had not been mitigated. Patients potentially had access to a cellar that we considered to pose a safety risk and a gate, that could allow patients to leave the site unseen and unsupervised, was not secured.
- The door to the cellar was unlocked during our inspection on 10 August. The manager said this was because records were being archived there and because maintenance equipment, occupational therapy equipment and cleaning materials were stored there. The cellar steps were cracked on the edges and the carpet was loose on some steps. The manager said that the maintenance staff had left the door unlocked but it was locked when we identified it. When we inspected on 17 August 2015 the lock to the cellar door had been changed and only the nurse in charge had access to the key. The door was opened by the nurse in charge so we could look at the cellar. The nurse walked away and left it unlocked for the time we were there. This posed a risk to patients who could access it. One staff member told us that the cellar door was often left unlocked at night. Since our inspections, all equipment stored had been moved to other areas so that staff should not need to access the cellar. The operations director advised us that the cellar steps would not be used until they had been repaired.
- At our inspection on 13 August, the door to the gate from the courtyard to the main garden was locked but could be opened by pulling it without force. This gave access to the garden, which was enclosed by a wire fence about five feet high. From there was access to the car park, which allowed unrestricted access to the main road and the local community. We saw at our inspection on 17 August that the lock had been changed and the gate was now secured.
- Although staff had failed to ensure that the building and grounds were safe, they had taken some steps to assess and manage risks. The manager had completed a fire risk assessment and, as a result of this, had cleared the cellar and boiler room. Staff did regular environmental checks and had increased their observation during the refurbishment works and the manager had positioned a member of staff on the first floor to stop patients accessing this area to keep them safe from harm.
- At our inspection on 10 August, we looked at the clinic room and saw that this was properly equipped and clean. However, we spoke with an agency registered nurse who had been working at the hospital for 12 weeks. They had been trained in how to use a defibrillator but they said it was locked away and they did not know where the key was. They said the defibrillator would be moved soon as this had been identified by staff as a risk but could not say when this would be. This could put the health and safety of patients at risk.
- The ward environment was tired and poorly maintained. Furniture was worn and in need of replacing and this had been planned for. The curtains in two of the bedrooms were too small for the windows. The manager told us these were to be replaced following refurbishment. There was an odour of urine in one bedroom. The manager said the flooring in the bedroom was to be replaced. However, the kitchen had a five star rating for food hygiene awarded by the environmental health department on 28 February 2014.
- The hospital had appointed an infection control lead who had completed an audit on 4 August 2015. This had identified several actions but there was no plan as to how or who was responsible to make the improvements needed.
- During our inspection on 17 August, we looked at the signing in/out book available in the reception area and we were provided with some contractor log sheets which were completed by the nurse in charge. It was evident that not all contractors had signed out of the visitors' book when leaving the building and no reference to timings were made. This was a contravention of the providers' own policy and a potential safety risk to patients and staff as it was impossible to tell who was in the building at any given time. This also posed a risk in the event of a fire.

Safe staffing

- The provider had estimated that there should be eight registered nurses and 7.5 support workers at the hospital.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- The provider informed us before our inspection that, between 1 April to 4 August 2015, five members of staff had left. In this period, there was a turnover of 22%. The vacancy rate was 13%.
- The provider had assessed that eight qualified nurses were needed. There were four qualified nurses employed and another post had been filled. Two registered nurses had left in the last six months.
- The operations director informed us that bank and agency staff covered 330 shifts between 1 May and 31 July 2015. Fourteen shifts had not been covered where there had been sickness, other absence or vacancies during that period. Agency and bank staff were block booked where possible to provide consistency for the patients.
- There were 2.5 vacancies for support workers. Two of the vacancies had been filled but the new staff could not start until checks were complete. The operations director told us that they were interviewing for a senior support worker at the end of August 2015. One support worker had been dismissed, one had resigned and another was absent due to long-term sickness.
- From 8am to 8pm there were two registered nurses and four support workers on duty. This had been increased during the refurbishment work, as one member of staff was needed to ensure that patients were not accessing unsafe areas and where builders were working.

Between 8pm to 8am, there was one registered nurse and two support workers on duty.

- Catering staff were off sick at the time of our inspection and agency catering staff were used to cover this role. Staff cooked meals for the patients at this hospital and for the other in the organisation.
- The operations director told us they were not aware that escorted leave was cancelled because of too few staff and there was no record kept of escorted leave cancelled. He said that staff were not aware that they should assess how many staff were needed to ensure the safety of all patients and staff and would take patients out regardless of any risks.
- A human resources manager had recently been recruited. They had completed an audit of all staff files and taken action to ensure that appropriate checks were done to evidence that suitable staff were employed. The human resources manager told us that they had put in place files for each agency staff member to ensure they were suitable to work there. They checked that the permanent and agency nurses had current registration with the Nursing and Midwifery Council (NMC). We looked at seven staff records and saw that safe recruitment processes had been followed.
- Training records showed that in the few months before our inspection eight staff had completed training in the Mental Capacity Act 2005, ten in food safety, seven in infection control and four in the Mental Health Act 1983. The operations director said that some training was done via e-learning but that the IT system was not up to date and staff had difficulty accessing it. A new server had been ordered as a result. One staff member told us they were on annual leave so had not received any of this training.
- At the request of CQC, a fire safety officer from West Midlands Fire Service visited on 3 September 2015. The officer found that kitchen staff had not been trained to use the fire extinguishers. The officer was also concerned that staff had received only online training in fire safety and advised the manager to ensure that staff had further face- to- face training.

Assessing and managing risk to patients and staff

- At our inspection on 10 August, we looked at the records of four patients who were detained there under the Mental Health Act 1983. On all of the leave forms we looked at there were blanket mandatory conditions regarding medication and compliance with care plans. These should be individual. The forms did not indicate whether the patient had the capacity to consent to the conditions or if they understood what was expected of them while out on leave.
- The operations director told us that staff would take patients out without assessing the risks to the patient, staff and the public and the four records we looked at confirmed this. However, to improve this, pre-ward-round reviews had been started for each patient two weeks before our inspection. These involved the patient and nursing staff and aimed to highlight the risks before the patient went on leave.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- On 10 August, we looked at all nine patients' records. Each record included a risk assessment. However, they did not identify each patient's individual risks and what support staff should give to reduce these.
- One of the patients was not detained under the Mental Health Act 1983 but was an informal patient who had consented to treatment. On our visit on10 August, we found that there was no notice on display telling informal patients they could leave when they liked. This was put up later that day after we drew it to the attention of staff. Staff were unsure about the rights of the informal patient and told us they would try to stop the patient for their own safety if they tried to leave.
- Staff told us that patients were searched on return from their leave. However, a search policy was not available and none of the patients' care plans included information as to how and why they would be searched.
- There were no records of restraint. The manager and operations director told us that restraint should not be used at the hospital but we saw in incident monitoring records that there had been times when restraint was used. Staff told us that restraint was not used and that managers had told them that if a patient became aggressive they should de-escalate the behaviours. However, staff told us that they did not know what was meant by de-escalation for each patient or how to do it. Staff had not received de-escalation training.
- Incident monitoring records we looked at showed that there had been three incidents since April 2015 where a patient had been aggressive or agitated and staff had restrained the patient to control the situation.
- Following our inspection, we asked the provider for their policy on managing and preventing violent incidents. This referred to previous legislation and was last revised in October 2008.
- It was not clear which staff had received training in safeguarding vulnerable adults from abuse as training records were not up to date. In one patient record, we saw three incidents were recorded. Two of these related to the patient being harmed by another patient and the other incident was about the patient's money going missing. None of these three incidents had been referred to the local safeguarding team for investigation and the CQC had not been notified of these, both of which should have been done. The manager and operations director were unaware of their responsibility to report safeguarding incidents to the CQC and were unsure how to do this. There were no safeguarding alerts or concerns received by CQC regarding this hospital for the period 1 January 2014 to 19 July 2015.
- The manager told us that some nurses were not good at identifying that incidents between two patients were safeguarding and needed to be reported. The manager had spoken with nurses about this.
- A pharmacy provider had been employed to oversee the management of medicines. A CQC pharmacist inspector visited on 30 September 2015. They found that two patient's had medication prescribed that was not on their current certificate to consent to their medication. The pharmacist who provided support to the hospital had completed an audit prior to taking over the dispensing contract which was sent to the hospital on 16 July 2015. They had identified this during their audit but this had not been rectified over two months later when the pharmacy inspector visited. This meant that action was not taken to mitigate identified risks and medicines were not managed in a safe way for patients.
- The pharmacy inspector found that emergency medicines were available for use but there was no evidence that these were regularly checked. Staff had no knowledge of any protocols for use of emergency medicines. Staff also had no knowledge of medication alerts being recorded and actioned. This meant that staff providing care or treatment to patients using the service did not have the competence and skills to do so safely. Staff had received medication training in July 2015.
- The pharmacy inspector checked the oxygen cylinder and found it had expired on 28 April 2011. There was no indication that it had been tested to see if it was still in working order. The manager and a registered nurse were aware that oxygen was available in the clinic room. However, neither of them knew the process for checking to ensure it was safe to use when needed. This meant that the risks of using the equipment provided had not been assessed and therefore action could not be taken to mitigate these risks.
- At our inspection on 13 August, we found that an agency qualified nurse on their second shift there had been in charge overnight but did not know where the

Long stay/rehabilitation mental health wards for working age adults

Inadequate

paracetamol was kept. One patient had requested pain relief but had not been given it. This was an example of important information not being given to agency staff to ensure the safety and wellbeing of patients.

- Staff told us that patients' children visited the hospital. There was not a visitors' room available. Staff and patients said that their visitor's saw them in communal areas or in the garden. There was no room that was suitable for children who visited. The manager told us that staff did not receive training in safeguarding children.

Track record on safety

- There had been no adverse incidents recorded.

Reporting incidents and learning from when things go wrong

- At our inspection on 13 August, we saw that an agency registered nurse who had been in charge overnight had not been able to record an incident as they did not know where incident forms were kept. The two support workers on duty with them also did not know where these were kept. The provider informs us that incident forms were kept in a clearly marked draw in the office and a written index of forms was kept on the top of the office desk, indicating where each form was located
- At our inspection on 10 August, we looked at incident monitoring forms from April to June 2015. These identified incidents where restraint had been used. The action plan for all three incidents was to look at alternative ways of managing the situation with staff and to provide training in de-escalation. The form stated that this was allocated to the manager to action. There was no date stated for this and the manager was unable to tell us when this training would be done. The operations director told us that the incident monitoring forms currently used were not ideal but a planned electronic incident reporting system would be better.
- All staff spoken with told us they did not receive feedback following incidents. The manager and operations director told us that reflective practice sessions had started to be held with staff. These were led by the psychologist. They said this would help to debrief staff following incidents and assist in making changes as a result of incidents.

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

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- At our inspection on 10 August, we looked at the care plans of all the nine patients. The care plans were not person centred. They did not show staff how to support patient recovery and to meet their individual needs.
- Records of patients' physical health checks were kept in a separate file. We saw that these had been completed regularly for seven of the nine patients.
- Two patients' records contained blank physical health assessment forms. The assessment form for one patient said their physical health needs should be reviewed every three months but there was no evidence that had happened.

Best practice in treatment and care

- Staff told us that psychological therapies as recommended by NICE were not offered to patients. However, the hospital offered rehabilitation to patients and these therapies would be important to promote the recovery of patients. Therapeutic interventions were not assessed and based on individual patients' needs. Psychology assistants employed there had started to assess patients so that appropriate interventions could be used.
- Following our inspection, we requested a care plan for one patient. This included a record of the patient's dental appointment on 4 August 2015. Staff had recorded that the patient was unable to have treatment as the list of medication requested at their previous appointment had not been brought by staff. This meant that the patient's treatment was delayed for a further two weeks when the appointment could be rescheduled.

Skilled staff to deliver care

- In the last few months, the professionals who worked at the hospital had changed and new staff had been

employed. An occupational therapist (OT) worked at this hospital 2.5 days a week. There was one vacancy for another full time OT. A psychologist worked at the hospital four hours a week and supervised the two psychology assistants. They also held reflective practice sessions for staff but did not offer psychology input to patients. The psychology assistants and OT worked in both of the provider's hospitals. A staff grade doctor was employed as a locum for three months and worked at Harriet Tubman House two days a week. They were supported by a consultant psychiatrist. There was always a doctor on call. All patients were registered with a local GP.

- The manager was a registered nurse and provided managerial supervision for the nurses employed there.
- Agency staff told us they had received an induction. We looked at agency staff induction records and found that these were from the agency as opposed to the provider. Some items included were not related to this hospital, for example, bedpans and the use of hoists. The length of time of the induction was not stated on the form so it was not clear how long it took to complete.
- One agency member of staff who had worked there for two shifts and was in charge was unaware of how to report an incident as they said they had not been shown this. They were also unaware of where painkillers were kept, which meant that a patient in pain had not received them when needed.
- Out of five staff personnel files we looked at we saw in one file that the staff member had received two supervision sessions since May this year. Before that, they had not received supervision for a few years. There were no records for other staff that showed they had received supervision.
- The operations director said that funded training and increments were now offered to registered nurses to make the recruitment package more attractive.
- None of the staff had received training in breakaway or de-escalation techniques. One staff member told us that the managers had told them they must not restrain the patients but use de-escalation when a patient became aggressive. However, they said they did not know what this meant as they had not received training.
- The provider informed us before our inspection that none of the staff employed had received an appraisal.

Multi-disciplinary and inter-agency team work

- Weekly multi – disciplinary team (MDT) meetings were held which involved the whole team, the patient and their relatives where appropriate. Each patient had a MDT meeting every three weeks unless their needs had changed.
- From reviewing care plans, it was difficult to see how patients' MDT meetings affected their day-to-day care and treatment. However, recently a pre-ward round review form had been implemented. This was completed by staff working with the patient and helped the patient to focus on their individual goals and aims.
- The psychologist led weekly MDT clinical reflective practice meetings.
- There was a handover between each shift, which all staff attended. If staff started after the handover, they were given a handover when they started work (for example, domestic staff and psychology assistants).
- The lead nurse from the CCG had recently visited the hospital and had started to work with staff there. The lead nurse had informed the manager to make safeguarding alerts to the local safeguarding team where the nurse had identified these. However, the manager was not aware that these were also required to be reported to the CQC. We were informed by local safeguarding teams of safeguarding incidents reported.

Adherence to the MHA and the MHA Code of Practice

- Eight of the nine patients were detained there under the MHA. We looked at four detained patients' files. All treatment was given under an appropriate legal authority. We saw specific capacity assessments pertaining to treatment. The consent to treatment forms were kept with the medication charts. However, in one file we saw the current form and a previous T3 were both attached to the medication chart, which could cause confusion to staff giving medication. This was highlighted to the Responsible Clinician on the day and the old form was removed. In three out of the four files, the detention papers were not fully available and were incomplete. Approved Mental Health Professional reports were not available in these files.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- We saw evidence that patients were made aware of their rights. However, we were unable to see evidence of a discussion about rights on detention. The reason for this was that some of the patients had been there for several years and their records were archived. We saw that further attempts to explain rights were made to patients. Information was provided in an appropriate and accessible format and was displayed on the notice board.
- We saw the Second Opinion Appointed Doctor's (SOAD) consultation with statutory consultees in the patient's files. However, we were unable to locate the Responsible Clinicians' discussion with the patient in respect of the SOAD's decision.
- In one file we were unable to locate a S61 review of treatment report. This requires that, where a patient has received treatment certified by a SOAD, a report on the treatment and the patient's condition must be given by the approved clinician in charge of the patient's treatment to the CQC. These reports are required generally when a patient's detention is renewed following a second opinion or when the CQC requires one.
- A review of the leave forms showed that leave was authorised through a standardised system. This included the conditions of leave, the start and expiration date and type of leave. We saw leave forms were signed by the patients and copies were offered to patients except for one. Risk assessments before leave was authorised were unavailable and staff confirmed that these were not completed before leave was taken.
- We found on all of the leave forms there were blanket mandatory conditions regarding medication and compliance with care plans. The forms did not indicate whether the patient had the capacity to consent to the conditions or if they understood what was expected of them whilst out on leave.
- Old leave forms were scored through to avoid errors being made.
- There was evidence of tribunals and managers hearings taking place and we saw reports of these.
- The MHA administrator had been in post since 1 July 2015. They worked full time and were based at another hospital within the organisation. They had six years' experience in an NHS trust as an MHA administrator and had completed the training required for that role.
- The MHA administrator had recently completed an audit that covered treatment, leave, rights and advocacy. An action plan had been sent to the nurse in charge and the managers were copied in. However, we found that the actions required from this had not been implemented at the time of our inspection.
- There was evidence in the files that patients had been informed of the Independent Mental Health Advocacy service. They held a drop in session there once a month.

Good practice in applying the Mental Capacity Act

- Four staff told us they had recently received training in the MCA. Training records showed that eight staff had received this training. The MHA administrator also told us they had completed training in the MCA and DoLS.
- We looked at the file for the informal patient. Regular capacity assessments relating to the decision for the patient to stay there had been completed. The patient had fluctuating capacity and this was evident from the frequency of the capacity assessments.
- An application had been made to the local authority for a Deprivation of Liberty Safeguard (DoLS) for an informal patient. It was not clear in the records we looked at whether or not this had been authorised. The Responsible Clinician (RC) told us that it was. The RC also said the patient had capacity to make decisions so the DoLS should have been withdrawn. This was done when we identified this. Three members of staff spoken with told us that if the patient tried to leave they would try to stop them. The safeguards are to ensure that any restrictions on a patient's freedom are the minimum necessary. However, as the patient was not detained under the MHA this was being used to prevent them from leaving the hospital.

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

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Inadequate

Kindness, dignity, respect and support

- During our inspection on 13 August, we observed that staff did not always respect patients' privacy and dignity. For example, staff told us that a patient was 'aggressive' in front of them. This did not respect the patient's privacy or dignity and the patient looked upset by this comment made to a visitor. We observed a staff member stood in the lounge with their arms folded watching patients but they made no attempt to engage with them. This showed no respect for the privacy of the patients who were sitting in the lounge.
- One patient said that they were comfortable there; staff were not abusive and did not shout.
- We observed that staff knocked on patients' doors before entering which respected their privacy.
- From speaking with staff and the manager and observing the handover, we found there was confusion about how to meet one patient's continence needs. There was a care plan for this, however, the care plan had limited information on how to inform staff. We asked for a revised one to be written and it was sent to us. The care plan demonstrated that the advice on how to meet the patient's needs from the continence nurse contradicted the advice given by the manager to staff. The manager told us that the patient was not to wear pads but the continence nurse had said and the care plan stated that the patient should wear pull up pads. We saw that some staff followed the advice of the manager and others that of the continence nurse. This resulted in the patient being incontinent and becoming distressed when staff supported them with their personal care.
- One patient's care plan included advice from the manager for staff about the triggers to identify that the patient needed to go to the toilet for a bowel movement. Records we looked at showed that staff had not followed this. This had resulted in the patient being incontinent of faeces and becoming agitated when staff supported them with their personal care. This meant that the patient was not treated with dignity and respect and their independence was not promoted.
- At our inspection on 10 August 2015, we could see into patients' bedrooms from the garden area. This was the area where patients smoked so did not ensure patients' privacy when in their bedroom.
- Due to the refurbishment work, patients had been moved to alternative bedrooms. We saw that their belongings were stored in bags and cases in their bedrooms. Two patients told us the refurbishment was taking too long and this impacted on their wellbeing.

The involvement of people in the care they receive

- There was no evidence in the care plans that the patients' wishes about their care and treatment had been considered. However, one patient said they and their relative were involved in care planning meetings.
- Weekly patient meetings were held and we saw minutes of these. These included reference to patients saying that the refurbishment was taking too long and they were unsettled by this. We saw that patients' belongings were stored in bags and suitcases and patients told us their views about this had not been listened to.
- Daily diary meetings had recently been implemented where patients planned their day with staff. It was too early to see the results of this and if it had improved the outcomes for patients.
- Advocates were involved and visited monthly. There was information displayed about how to contact an advocate. Patients told us they knew how to do this.
- The manager told us that relatives were involved and they planned to start a carers group.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Inadequate

. **Access and discharge**

- The hospital has 15 beds; 9 of which were occupied at the time of our inspection.
- We looked at all the patients' care plans. There was no evidence of discharge planning. One patient had lived

there for 15 years and other patients had been there for several years each. There was no evidence that the service sent progress reports to the Clinical Commissioning Groups (CCG) who were responsible for the placement and funding of the patients' stay. The CCG told us they had not requested these until this year.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had identified that the refurbishment was needed to improve the facilities for the recovery of patients and at the time of our inspection, the hospital was being renovated. This meant that rooms had changed their use, patients had been moved into other bedrooms and part of the first floor was not being used. There was one lounge/ dining room. A separate quiet room had been developed on one side of this room.
- There was not access to a visitor's room during the building works. However, a new visitors' room would be created as part of the work. Patients told us that their visitors saw them in the lounge, the quiet room or the garden. The quiet room was not private as there were windows where people in the lounge and garden could see inside. Patients and staff told us that patients' children visited them at the hospital. One patient told us that one of their relative's children visited them and liked to run around but this was not safe in the communal lounge. The facilities provided did not allow for patients' children to visit safely or ensure that their visits were private and their dignity was respected.
- Patients had free access to the courtyard part of the garden and this included the smoking shelter. This led to a locked garden area where patients went when supervised by staff. Patients and staff told us that they grew fruit and vegetables in that part of the garden.

The only seating provided in the garden was in the smoking shelter.

- Patients told us that the food was good and there was always enough to eat. In the dining room, patients could make hot and cold drinks until 10pm. After that, patients could request drinks from staff. A small kitchen area was provided, where patients could make their breakfast and snacks. Staff told us this was kept locked to keep patients safe and patients were always supervised when using this kitchen.
- The manager told us that patients had chosen the colours for their bedrooms to be painted from a range of four colours. However, the manager then told us that patients were to move to other rooms after the refurbishment. The manager told us that patients had chosen the colour for the lounge to be painted in.
- During the refurbishment works the space for patients to store their belongings was limited. We saw in patient's bedrooms that their belongings were stored in bags and suitcases. Two patients told us that the work was taking too long.
- An occupational therapist (OT) had been employed to work at this hospital for two days a week and two days at the providers other hospital. There was a vacancy for another OT. A full time activity worker had also been employed.
- Patients told us that there were not many activities but they did go out shopping when they had their leave. We observed patients sitting in the lounge watching TV, listening to music or asleep. One staff member told us that there was not much for patients to do and during the summer when colleges were closed there was less activity. However, activities were not provided to replace college courses. We saw no books or magazines. There was one game and staff said that other activities were kept in a locked cupboard. The OT and activity worker had begun on the first day of our inspection to set up a group activity each afternoon from Monday to Friday. These included cooking, Zumba, communication and music appreciation. An interests list was developed with the patients so to help to motivate them. Support workers were to be involved in these activities.
- The OT told us that by the end of November 2015 each patient would be assessed using a standardised tool. Individual plans would be developed and would focus on rehabilitation.

Meeting the needs of all people who use the service

- One patient had difficulty mobilising due to their physical healthcare needs. Adjustments were being made to their bedroom and bathroom as part of the refurbishment works. We saw this patient had difficulty when they walked across the lounge and held on to furniture and the walls to balance themselves. We asked the doctor if the patient had a walking aid. They told us the patient had been assessed by a physiotherapist and

Long stay/rehabilitation mental health wards for working age adults

Inadequate

had a walking stick but they were not sure why the patient did not use it. Staff told us that they were not sure whether the patient used a walking stick. One staff member thought it had been taken from the patient so they did not use it as a weapon. This does not promote independence or the safety of the patient.

- Information was available to patients on their rights and advocacy services. We did not see any information about how a patient could complain and how this would be investigated.
- All patients told us the food provided met their cultural and religious needs.
- All patients told us they could access spiritual support when they wanted to. One patient told us they were supported by staff to visit the temple when they wanted to.

Listening to and learning from concerns and complaints

- There were no complaints recorded in any of the records we looked at. The provider told us that there had been no complaints received in the last 12 months.
- All patients told us they knew how to make a complaint. However, one patient told us they were not confident they would be listened to. For example, they had complained that their bedroom was cold but they said nothing had been done about this.
- We saw an empty comments box in the dining room. Paper was provided for recording comments, concerns, compliments and complaints.
- A complaints policy was not available for patients and their relatives to know how to complain and what would be done with their complaint or comments.

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

Inadequate

Vision and values

- The organisation did not have a vision and values statement.
- Staff knew who the most senior managers in the organisation were and these managers had visited the hospital.

Good governance

- There was not a governance board or governance arrangements for Options for Care Limited. The operations director informed us in July 2015 of plans to set this up however this had not yet been implemented.
- We found that strategic planning was not done and any action taken was reactive. The operations director confirmed this during this inspection.
- We identified during our inspection that the building works caused disruption to patients and sufficient action was not taken to mitigate the risks to patient's safety and welfare. We raised our concerns about this with the provider at a meeting on 18 August 2015. Following this, the building work was suspended.
- We asked the manager and operations director if they were familiar with and had a copy of the 'CQC Guidance for providers on meeting the regulations.' They told us that they had not seen this publication and did not have a copy. A copy was not available at the hospital.
- The operations director and manager told us they had raised safeguarding alerts to the local authority. However, we saw that not all the safeguarding incidents recorded in patient's records or on the incident monitoring forms had been referred to the local authority. None of the incidents had been notified to the CQC, as the managers were unaware that the regulations required this.
- The provider had not submitted an audit schedule as requested by CQC and have not been able to tell us what this is for the organisation.
- We saw that monthly health and safety inspections had been done. These stated that action was needed to make improvements however, they did not specify how or who was to take action to mitigate the risks identified.
- We found no evidence to demonstrate that lessons were learnt from audits and that action was taken to make improvements where needed.
- We found that incidents had not been monitored and analysed to identify themes so that action could be taken to reduce further incidences.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- The provider did not use key performance indicators or other indicators to gauge the performance of the staff team.

Leadership, morale and staff engagement

- The provider informed us before our inspection that the sickness rate from 1 April to 4 August 2015 was 13%.
- The current manager had been working there for five months. They had applied for registration with the CQC. The operations director had been working for the provider for five months. They were the nominated individual for the provider.
- Four staff spoken with during our inspections told us that their morale was low and that the new managers had brought in changes that they did not think respected the patients or staff. They told us that changes were not planned but reactive to situations. We found this during our inspections. For example, the building works were suspended when we raised concerns about the systems and checks put in place to mitigate the risks to patients, staff and visitors. In the two months before our inspections we had received seven enquiries from anonymous staff members about the safety of the building works and how this impacted on patients', the changes made had not considered risks to patients' health and safety and that staff were not given appropriate training and support.
- One member of staff told us they were supported by the managers however the building works had made the last few months a stressful time.
- Two staff told us that they did not feel able to raise concerns without fear of victimisation.
- Staff meetings were held, however, four staff told us that these consisted of managers handing over information and they did not feel able to speak their views. A staff survey had not been completed.

Commitment to quality improvement and innovation

- We did not see any evidence of the use of improvement methodologies or participation in national quality improvement programmes.

Outstanding practice and areas for improvement

Outstanding practice

None noted.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that risk assessments show staff how to support patients to mitigate risks to their health and safety.
- The provider must make arrangements to ensure that patients and staff are safe during building and refurbishment works.
- The provider must ensure that the environment is safe for patients and staff at all times.
- The provider must ensure that staff receive the necessary training and support so they know how to provide safe care and treatment to patients.
- The provider must ensure that patients' medicines and medical equipment is used safely and action is taken to mitigate identified risks.
- The provider must ensure that incidents are monitored and any themes identified so that action can be taken to reduce further incidents occurring.
- The provider must ensure that all patients are involved in their care planning.
- The provider must ensure that care plans show staff how to support the patient to meet their needs.
- The provider must make arrangements to ensure that all staff and the environment respect the privacy and dignity of patients.
- The provider must ensure that the independence of patients is promoted to enable their recovery and rehabilitation.
- The provider must ensure that all staff receive training in breakaway and de-escalation.
- The provider must ensure that all staff have knowledge of the Mental Capacity Act 2005 and how this legislation affects the patients they support.
- The provider must ensure that systems are in place to assess, identify and monitor the risks to patients and the quality of care provided. Audits must identify how improvements are to be made and who is responsible for this.
- The provider must ensure that all staff have an appraisal.
- The provider must ensure that the views of patients and staff are sought to assist in improving the service.
- The provider must ensure that all staff receive the appropriate training and supervision to ensure that there is always a sufficient number of skilled and experienced staff on duty.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that patient's MHA records include the required paperwork to comply with this legislation.
- The provider should make arrangements so that children who visit are safe.
- The provider should ensure that psychological therapies recommended by NICE are offered to patients where appropriate.
- The provider should ensure that all patients and their relatives know how to make a complaint.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the 2014 Regulations (Safe care and treatment) Risk assessments did not show staff how to support patients to mitigate risks. Appropriate measures had not been put in place to ensure that patients and staff were safe during the building works. Some areas of the environment were not safe and risks to patients had not been mitigated. Staff were not supported and trained so they knew how to provide safe care and treatment to patients. Medicines and medical equipment were not managed in a safe way for patients and action was not taken to mitigate identified risks. Incidents were not monitored to ensure that any themes were identified and action taken to reduce further incidents. This was a breach of Regulation 12 (1) (2) (a) (b) (c) (d) (g)

This section is primarily information for the provider

Enforcement actions

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 **Regulation 9 of the 2014 Regulations (Person Centred Care)** Patients were not involved in their care planning. Care plans did not show staff how to support patients to meet their needs. This was a breach of Regulation 9 (1) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 of the 2014 Regulations (Dignity and respect)** Staff did not always respect patients' privacy and dignity. Patients were not supported to promote their independence. The environment did not always respect patients' privacy. This was a breach of Regulation 10 (1) (2) (a) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 of the 2014 Regulations (Safeguarding service users from abuse and improper treatment)** **Staff had not received training in breakaway and de-escalation. This had resulted in patients being restrained.** **Staff did not have knowledge of the Mental Capacity Act 2005. This had resulted in inappropriate applications made to deprive patients of their liberty.** **This was a breach of Regulation 13 (1) (2) (3) (4) (b (7) (a) (b)**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 of the 2014 Regulations (Good governance)** **Systems were not in place to assess, identify and monitor the risks to patients and the quality of care provided.** **Health and safety and infection control audits were completed but it was not clear how improvements were to be made as a result.** **Managers did not conduct appraisals of staff's work performance.**

This section is primarily information for the provider

Enforcement actions

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 **Regulation 18 of the 2014 Regulations (Staffing)** Staff had not received appropriate training and supervision to ensure that there was always a sufficient number of skilled and experienced staff on duty. This was a breach of Regulation 18 (1) (2) (a)

Patients' views were not sought to assist in improving the service.

This was a breach of Regulation 17 (1) (2) (a)(b) e (f)