

# Oxford University Hospitals NHS Foundation Trust Nuffield Orthopaedic Centre

## Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected the Oxford Centre For Enablement inpatient ward on 9 August 2017; this was an unannounced focused responsive inspection in response to a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) notification concerning an incident that occurred on the 8 July 2017.

The rationale for this inspection was to follow up on the RIDDOR, which gave details of possible avoidable harm that had occurred to an inpatient, and to ensure care was being provided in a safe way for the current patients.

Therefore, CQC only inspected and gathered evidence relating to the safe care of patients through observation, staff interviews and evidence gathering.

### **We have not rated this service as this was an inspection, which focused on safe care in one area.**

- Areas of the ward were not secure placing patient at risk as some patients would be able to leave the ward and grounds without being witnessed. The trust has put plans in place to address the issues identified with entry and exit points and the main unlocked gate.
- Patients' records were predominantly electronic, however these were difficult to integrate and there was not a clear contemporaneous record of care.
- Risk assessments were being completed on admission; however, these were not consistently being reviewed and updated particularly when there was a change with the patient's conditions. Neither were risk assessments being used to ensure plans of care reflected the patient's needs.
- Deprivation of Liberty safeguard applications were being submitted in response to some recognised occurrences where people were being deprived of their liberty such as the use of pen release lap belts and unit's tagging system. However, patients were on occasion being deprived of their liberty without due consideration being given to the need to submit an application to gain consent to deprive a person of their liberty such as the use of bedside rails.
- There was a lack of evidence that formal mental capacity assessments were being completed and documented when a patient was considered to lack capacity.
- Staff were working flexibly to try to ensure there were sufficient staff to meet the patients' needs, however to achieve this skill mix of staff was being impacted on.
- Medical staff would place people under formal one to one supervision if they assessed them to be at risk. Other staff would place patients under intermittent one to one supervision if they felt the patient's behaviour was placing them or others at risk. There was no clear process for this and no criteria therefore staff were at risk of unintentionally depriving patients of their liberty.

### **However:**

- Staff were clear about their responsibility to report incidents and how to do this. There was also a process to feed back the outcomes and required actions from any investigations.

### **There were also areas of poor practice where the trust needs to make improvements.**

#### **Importantly, the trust must:**

- Review the standard of record keeping ensuring each patient has a contemporaneous record of care, with a plan of care which reflects their needs, taking into account the assessment of risk associated with delivering the required level of care.
- Ensure plans of care are reviewed on a regular basis and when there is a change to the patients' needs to ensure they remain current and relevant to the needs of the individual patient.

# Summary of findings

- Ensure mental capacity assessments are completed and documented for all patients considered not to have capacity. Where a patient lacks capacity, consideration must be given to what would be in the patient's best interest and if they are to be deprived of their liberty, safeguards required by legislation must be put in place.
- Monitor and review the staffing levels on the inpatients ward to ensure they are at the required level with the correct skill mix to meet the assessed needs of the patients.
- Ensure planned work to improve the safety of the unit is completed in a timely way.
- Implement clear guidance and criteria for staff to follow when considering placing patients under one to one supervision.
- Ensure that all aspects of the duty of candour regulations are adhered to and conversations are clearly documented.

## **In addition the trust should:**

- Ensure there is a clear system in place which is understood by staff to monitor application for Deprivation of Liberty safeguards to track both the application and the expiry dates of any such applications to ensure patients are not unlawfully deprived of their liberty.
- Ensure the work to change control systems or the entrance and exit points of the unit, is completed in the agreed time scale.
- Review the security control measures in place for all the gates that lead from the inpatient ward garden area to help ensure it is a safe place for patients to roam.
- Take action to ensure the conservatory is a safe area for patients to use when it is raining.
- Take account to ensure all staff are aware of the importance of closing and securing all doors assessed as needing to be shut for patient safety reasons.
- Implement a system to ensure the unit is secure and safe out of hours.
- Ensure staff are up to date with their mandatory training.
- Consider the introduction of clear guidance as to when a patient becomes a risk and the use of the tagging system should be used for their own safety.
- Ensure there is sufficient medical cover to provide a safe service.

**Professor Edward Baker**

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

**Medical care  
(including  
older  
people's  
care)**

### Rating **Why have we given this rating?**

We have not rated this service as this was a focused inspection of safe services for one services.

- Areas of the ward were not secure placing patients at risk, as some patients would be able to leave the ward and grounds without being witnessed. The trust has put plans in place to address the issues identified with entry and exit points and the main unlocked gate.
- Patients records were predominantly electronic, however this were difficult in integrate and there was not a clear contemporaneous record of care.
- Risk assessments were being completed on admission; however, these were not consistently being reviewed and up dated particularly when there was a change with the patient's conditions. Neither were risk assessments being used to ensure plans of care reflected the patient's needs.
- Deprivation of Liberty safeguard applications were being submitted in response to some recognised occurrence where people were being deprived of their liberty such as the use of pen release lap belts and units tagging system. However, patients were on occasion being deprived of their liberty without due consideration being given to the need to submit an application to gain consent to deprive a person of their liberty such as the use of bedside rails.
- There was a lack of evidence formal mental capacity assessments were being completed and documented when a patient was considered to lack capacity.
- Staff were working flexibly to try to ensure there were sufficient staff to meet the patients' needs, however to achieve this skill mix of staff was being impacted on.
- Medical staff would place people under formal one to one supervision if they assessed them to be at risk. Other staff would place patients under intermittent one to one supervision if they felt the patient's behaviour was placing them or others at risk. There was no clear process for this and no criteria therefore staff were at risk of unintentionally depriving patients of their liberty.

However:

# Summary of findings

- Staff were clear about their responsibility to report incident and how to do this. There was also a process to feed back the outcomes and required actions from any investigations.
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# Nuffield Orthopaedic Centre

## Detailed findings

### Services we looked at

Medical care (including older people's care)

# Detailed findings

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### Detailed findings from this inspection

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## Background to Nuffield Orthopaedic Centre

The Oxford Centre for Enablement (OCE) is part of Oxford University Hospitals. It is located on the site of the Nuffield Orthopaedic Centre, which is located away from the main acute hospital campus.

The Nuffield Orthopaedic Centre was merged with Oxford University Hospitals in 2011. The building housing the OCE is part of the 'retained' estate and is supported by the PFI security team and maintenance processes.

The OCE is the Wessex regional enablement centre and is commissioned by NHS England (NHSE) to provide specialist neurological rehabilitation for up to 26 patients. The OCE is the only Level 1(1B) unit funded by NHSE for the 'Wessex region'. This area covers a wide area (from Oxfordshire, Buckinghamshire, Berkshire, Hampshire, Isle of Wight and Dorset).

The Oxford Centre for Enablement (OCE) is commissioned to provide ongoing specialist rehabilitation to high acuity patients. Tertiary 'specialised' rehabilitation services (Level 1) such as this one, are high cost / low volume services, which provide rehabilitation to patients with highly complex needs that are beyond the scope of their local and district specialist services. They are provided in co-ordinated service networks planned over a regional population of 1-5 million through specialised commissioning arrangements.

Specialist rehabilitation is the total active care of patients with a disabling condition, and their families, by a multi-professional team who have undergone recognised specialist training in rehabilitation, led by a consultant trained and accredited in rehabilitation medicine.

Such patients are typically those with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioural and social problems. They require specialist input from a wide range of rehabilitation disciplines (for example, rehabilitation-trained nurses, physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, orthotics, social work etc.) as well as specialist medical input from consultants trained in rehabilitation medicine, and other relevant specialties such as neuropsychiatry.

This inspection was a responsive focused inspection following the receipt of a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) notification.

From 1 April 2015, the Care Quality Commission (CQC) has been the lead enforcement body for health and safety incidents that have occurred in a health and social care setting, where members of the public are injured or die.

We did not carry out a full comprehensive inspection but a focused responsive inspection, therefore CQC only inspected and gathered evidence relating specifically to the safety and safe care of patients through observation, staff interviews and evidence gathering.

This inspection was to examine processes and procedures at the OCE location to ensure that patients were safe within this environment and that risk assessments and interventions were in place to keep them safe.

# Detailed findings

## Our inspection team

Our inspection team was overseen by:

**Head of Hospital Inspections:** Alan Thorne, Care Quality Commission

Lisa Cook, Care Quality Commission Inspection Manager led the inspection team, supported by Julie Sprack and Rachel Wemyss, Care Quality Commission Inspectors.

## How we carried out this inspection

We inspected the premises of the OCE on an unannounced inspection on 9 August 2017 between the hours of 10am and 7pm. This was in response to a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) notification where avoidable harm occurred to a patient resident on the inpatient ward.

We spoke with thirteen staff, including senior managers, medical staff, front line clinical staff and contracted support staff. We reviewed five sets of combined paper and electronic records.



# Medical care (including older people's care)

## Overall

### Information about the service

The Oxford Centre for Enablement (OCE) inpatient service provides inpatient neurological rehabilitation for patients needing highly specialist rehabilitation from Oxfordshire and surrounding counties. It is part of the Thames Valley Trauma Network rehabilitation network.

The centre's primary goal is to ensure that each person with persisting disability and/or distress arising from disease or damage achieves the best level of social integration possible, whilst also considering equitable, fair allocation of limited resources

The ward has the capacity to admit up to 26 inpatients at any one time, depending upon staffing levels and the level of dependence of the patients being referred and admitted. Patients are considered suitable for admission if the patient has a neurological or neuromuscular condition, would benefit from the specialist neurological rehabilitation service available, would not gain an equal benefit from a more readily available service and would be safe in the environment. Patients may be admitted for anything between two weeks and several months.

### Summary of findings

#### Incidents

- Staff recorded patient incidents using an electronic recording tool. They were discussed at ward rounds, ward meetings and within the ward handover sheets. Staff we spoke with told us there was a high incidence of falls within the unit due to the nature of 'enablement' when patients are encouraged to redevelop mobility skills. However, there had been no recent high harm patient falls prior to the RIDDOR incident.
- The RIDDOR incident involved a patient gaining access to a 'secured' area at the weekend and coming to harm by falling down stairs in a wheelchair, this was being investigated as a serious incident (SI).
- In the previous twelve months prior leading up to July 2017, staff reported 86 patient falls without harm. 19 were from a bed, 17 from a chair or wheelchair, 28 whilst the patient was mobilising and 22, which were stated as 'unknown causes'.
- There was an internal trust process for potential serious incidents to be reviewed at a 72 hour incident review meeting. Minutes of these meetings confirmed these meeting were used to decide whether an incident was a serious incident (SI) and required further investigation. At this point, an incident would be confirmed as a case needing to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).
- A review of records relating the RIDDOR incident demonstrated the principles of duty of candour had been applied and the family had been informed of the incident. They had also been sent a letter asking if they would like to see the investigation report. However, there was no evidence of a written record of any discussions which took place with the family.

#### Safety thermometer

# Medical care (including older people's care)

- The service contributed data to the national safety thermometer audit. These were combined with the acute site for hospital-combined data. Therefore, an overall harm score was attributed to the trust rather than specific services.

## Environment and equipment

- We reviewed in detail the access door security in place on our inspection. There were variable door security measures within the ward, some doors had release buttons, some were secure requiring a 'fob' to gain access and some allowed free access.
- Most doors were fire doors and were fitted with centrally controlled closers for when the fire alarm was sounded. If the fire alarm was activated the doors would close automatically to reduce the risk of a fire spreading.
- There was open public access to the building from Monday to Friday between 8am and 5pm when the reception desk was manned. At other times including weekends the reception desk was unmanned; and a staff fob was needed for access or visitors used the ward's intercom.
- The main entrance doors to the ward doors were secured through 'fob' control at all times, however exit from the ward was through push button control. This led to the lift lobby area where there was a second set of doors which led to the ward. These were not secure and were observed to be often propped open.
- This meant patients could gain free access to this lift. Within the lift, large illuminated indicator buttons had directional arrows to guide the user. The ward staff explained that the free access was to enable some patients, assessed as safe to do so, could make their own way to their therapy appointments, which were located on the first floor.
- The first floor was accessible by the lift and opened into a first floor lobby with staff fob only access through the doors, however these doors were open at the time of inspection. We were told these doors were usually left open during the working day.
- There were eight points where patients could exit the ward/ building without restriction. The trust had started to review the safety of the unit with regards to exit and entry points. Since the inspection we have received confirmation the required work has been approved and is due to be completed in October 2017.
- The ward kitchen doors were seen propped open throughout the inspection, despite the requirement for them to be closed for public safety. The first floor kitchen door was also propped open and noted to be unattended throughout the inspection. There was a cleaner's storage cupboard on the first floor, which had a safety label alerting users of the storage of 'Control of Substances Hazardous to Health 2002 (COSHH). We observed the door to the cupboard left open and unattended when we were being shown around but it was securely locked later in the day.
- The internal ward conservatory lounge had unsecured wheelchair accessible push button access to the outside of the building. When we inspected the outside areas, there were three lockable but unlocked metal and wooden gates allowing free access to and from the grounds. The gates led to various site car parks and onto a busy road; there was a risk to patients should they gain access through the unsecured gates.
- We were told the security team routinely padlocked the external gates out of hours (from 8pm until 8am) but we were told by the security team manager there were ongoing issues of staff complaining when access gates were locked and padlocks being removed from the gates. There were no padlocks on the gates on the day of the inspection. We were informed by the trust that work to secure the gate from the garden to the carpark would be completed by the end of September 2017.
- There were security cameras on the OCE front door, but none on the conservatory or the external gates.
- We requested the environmental risk assessments for the area, none were initially provided. We were later provided with a document dated 16 April 2012. This did not include any assessment of the entrance and exit points of the unit or consideration of the closing and locking of doors. Following our inspection a health and safety risk assessment of the area was completed which identified concerns with the exit and entry points for the ward and the unit relating to patient safety.

# Medical care (including older people's care)

- On the day of our inspection, heavy rain was leaking into the conservatory from the outside doors, there was no absorbent matting and the floor was wet and a slip hazard to staff and patients.
- The multidisciplinary team (MDT) assessed patients who were a risk of absconding or leaving the building without medical authorisation, there was a patient tagging system in place for these patients. The centre commissioned the tagging system when the unit opened 6 years ago. The tagging alarm box was sited at the nurses' station; a member of staff also carried a pager, which should alarm if a patient wearing a tag left the building. The alarm would continue until staff reset it. We saw, from a review of reported incidents, there had been ten incidents of patients leaving the unit or absconding over the past 12 months, despite the tagging system being in place. Staff had not heard or the alarm had not activated when they left the building.
- We have now received confirmation from the trust the system has been repaired and 24 hour support service implemented in case of any future failings.
- The site security team undertook regular rounds to check for example, doors and windows were locked and there were no unauthorised people on site. According to their documentation, they were required to check the main door of the OCE building was secure, there was no indication they were required to inspect the inside of the building. On the day the RIDDOR occurred, the previous night security report did not report any unsecured doors within OCE. The day security report indicated no issues, their report shows that they were not informed of the patient incident or asked to check on the functioning of the door locks.
- In response to our concerns a new process was introduced which requires the security patrols to inspect the internal environment of the unit at least once at night. This system is not yet established and there is no evidence to date as to the impact to of this new initiative on patient safety.
- There was sufficient equipment available to help manage the patients' rehabilitation safely; this included specific wheelchairs, high low beds, crash mats and bedside rails.

## Records

- Patient records were a combination of paper and electronic. The electronic system was found to be difficult to navigate when patients had been within the unit for some time. There were issues in locating a contemporaneous record of care and in following a decision making process. For example, patients having one to one staff supervision and observation did not appear to have a detailed assessment and the justifications for any 'one to one' supervision was not easily accessible within the records we reviewed. Each different discipline using the electronic records appeared to use a separate part of the record to record in which made it difficult to track.
- We did not see any individual patients risk assessments for 'tagging' patients, and the senior ward staff could not locate the policy or guidelines for its use on the day of inspection. The guideline was located later.
- Patient safety risk assessments were fully undertaken when the patient was first admitted to use as a baseline. These included for example the patients' risk of falling, risk of developing a pressure ulcer and a nutritional risk assessment. However, there was variation seen in the re-assessment of these risks and the linking of them to individualised plans of care to reduce risk.
- Whilst the electronic system digitally 'signed' each entry by a staff member, the paper documents were not all signed and dated at each entry.

## Safeguarding

- Staff made a Deprivation of Liberty safeguard (DoLs) application for those patients who had been assessed by the MDT as requiring electronic tagging or who needed a pen removable lap strap for their safety whilst using their wheelchair. We did not see any evidence that the use of bed rails was considered restraint, there were no assessments in place for the use of bedrails and no indication their use was considered to be in the patients' best interest.
- When the staff used soft mittens with confused patients to prevent them from continually removing their treatment tubes, a DoLs application was not submitted.

# Medical care (including older people's care)

- Intermittent one to one supervision was not consistently being considered as a form of constraint or as being in the patients best interest at the time it was required.
- On inspection, we reviewed the records of patients who were being restrained under DoLs. We could not find any documented mental capacity assessments, which would inform staff the patient had no capacity and needed to be referred for DoLs. The trust policy states patients who lack capacity must be assessed using the Mental Capacity Act and Deprivation of Liberty Policy and the results clearly and accurately documented in the patient's healthcare records.
- While there was a trust wide system for monitoring application for Deprivation of Liberty safeguards, this was not clearly understood by staff. This was not supported by a local system and staff were unclear about the current position of applications they had submitted or expiry dates where applications had been granted. There was a risk patients were unlawfully deprived of their liberty.

## Mandatory training

- The trust mandatory training included for example fire safety, health and safety, adult and children safeguarding. Some training available had been deemed not required for this staff group, this included for example; conflict resolution practical and theory, electronic record keeping, health record keeping and consent.
- We reviewed the training records of the OCE staff for their compliance with mandatory training; overall, the team was 90% compliant. The lowest staff compliance was for blood transfusion at 61% with five staff who had not completed and resuscitation at 70% with ten staff who had not completed. Health and safety training had been completed by 94% of staff with two staff who had not completed it.

## Assessing and responding to patient risk

- The unit staff undertook a broad range of safety risk assessments when the patient was initially admitted, these included for example a falls risk, pressure ulcer risk, moving and handling and nutrition screening.
- The paper risk assessments were not all regularly updated in any detail, most just had a date inserted

on the back of the page, this was not signed or annotated although we were told it meant that the risk was as before or no change. In addition electronic records were completed but they did not hold the risk assessments.

- One patient's records showed that following a fall, there was no revisit of the risk assessment or detailed update written on their care plan despite this increased risk. For a second patient who had a falls prevention care plan, there was evidence this had been reviewed and updated when the patients started to stand and then mobilise with a frame.
- We observed bedside rails being used in the unit, however in the records we reviewed there was no evidence risk assessments were being used to inform the decision to use the bedside rails. Therefore, it was unclear if the risk of using the bedside rails had been considered and they were being used in the patient's best interest.
- If a patient was considered to be at risk of wandering then a tagging system would be used either with the patient's consent or through a Deprivation of Liberty Safeguards application. Oxford Centre for Enablement Patient Tagging system guidelines Nov 2016 did not include any information about when a patient became at risk, but mentioned the use of professional judgment.
- Patients assessed by the medical team at risk of harm could have formal one to one supervision implemented. On other occasions if staff were concerned about a patient's safety they would implement what was referred to as intermittent one to one supervision. There was no formal guidance for staff to follow when making this decision. Therefore, staff were at risk of unintentionally depriving patients of their liberty.

## Nursing staffing

- The ward staffing establishment was set at 49 whole time equivalents (WTE) for the safe care of 85% Category A level 1 patients (most challenging) within the 26-bedded unit. However, staff told us that the historical case mix had been up to 50% Category A level 1 patients, of which up to five patients could be having one to one supervision. Trust data provided however, shows that between 2014 until 2017 there

# Medical care (including older people's care)

were between 51 and 66% of Category A patients. Senior nurses told us that having the reduced numbers of Category A level 1 patients had enabled the unit to manage with the increasing number of registered nurse (RN) vacancies.

- The matron reviewed the unit's skill mix and patient workload or dependency weekly. Staff we spoke with told us they felt the nursing establishment had been set without a view on the dependency or acuity of the patients.
- The nursing establishment was 26.74 whole time equivalent (WTE) registered nurses, but at the time of the inspection had 8.07 WTE (30%) vacancy rate. The senior nurses had tried to fill the vacant RN posts with alternatives such as learning disability and Band 4 posts, however this diluted the RN skill mix and made the off duty more challenging to do. This also meant there were issues in managing clinical issues such as patient tracheostomies with a lower skill mix. The increased RN vacancies was escalated and was on the units local Risk Register with actions to try to lessen the risk.
- There was a further 1.10 WTE vacant in the health care assistant posts. Hence the total WTE vacancies in the unit were 9.14 WTE or 18.56% overall.
- The unit shift patterns were for five RNs and one band 4 and four health care assistants (HCAs) in the morning, five RNs and one band 4 and three HCAs in the afternoon and three RNs and two HCAs overnight. Any patients requiring one to one supervision had an additional staff member requested on top of these numbers.
- The CQC team reviewed two months of rosters; of 168 shifts 55 or 33% were seen to be rostered with just three or even two permanent RNs prior to temporary RN staff filling the gaps. The lack of permanent and experienced staff could mean delays in medicine administration and specific nursing interventions. A number of the unit's permanent staff were noted to work additional shifts through the bank to support the ward.
- A review of the trust's electronic record of patient dependency and staffing indicated that between 26

June 2017 and 9 August 2017 10% (10 out of 90 shifts) of early and late shifts were considered to be at risk. For the same team period 43% (39/90) were rated as at agreed numbers, the remaining 47% (51/90) were at a minimum level. Therefore, the majority of the time the unit staffing was either at the minimum level or below.

- A review of the trust staffing, showed that for the month of July 2017 the OCE had the lowest RN fill rate with 74.8% for day shifts compared to the rest of the wards or departments. They had also one of the lowest HCA fill rates with 77.5% for day shifts, they were the only ward or department with both RN and HCA fill rates flagged 'at risk'.
- On the morning of the day of the RIDDOR incident, the roster showed that there were three RNs, one band 4 and five HCAs on duty. The requests print out for bank staff showed that there were no additional shifts requested for the morning shift. There was one HCA request in the afternoon, which was unfilled, and two HCA requested and filled for the night. Therefore, the staffing was two RNs short but partially backfilled by a band 4 and an extra HCA. The records we reviewed showed that two patients were having one to one supervision on this day, which would reduce the available staff by two for the remainder of the patients. There were 23 inpatients, therefore the ward was 88% utilised. The staffing levels were assessed as being at minimum but not at risk.

## Medical staffing

- There was one part time consultant (seven sessions) and two locum consultants. One of the locums was due to leave in October 2017. The second locum had started in July 2017 initially for 6 months, their contract has since been extended for a further nine months. The service required three consultants; recruitment had been ongoing to fill the gaps. The risk had been escalated to the local risk register with actions to try and lessen the risk.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

- Review the standard of record keeping ensuring each patient has a contemporaneous record of care, with a plan care which reflects their needs taking into account the assessment of risk associated with delivering the required level of care.
- Ensure plans of care are reviewed on a regular basis and when there is a change to the patients' needs to ensure they remain current and relevant to the needs of the individual patient.
- Ensure mental capacity assessment are completed and documented for all patients considered not to have capacity. Where a patient lacks capacity, consideration must be given to what would be in the patient's best interest and if they are to be deprived of their liberty safeguards required by legislation must be put in place.
- Monitor and review the staffing levels on the in patients ward to ensure they are at the required level with the correct skill mix to meet the assessed needs of the patients.
- Ensure planned work to improve the safety of the unit is completed in a timely way.
- Implement clear guidance and criteria for staff to follow when considering placing patients under one to one supervision.
- Ensure the all aspect of the duty of candour regulations are adhered to and conversations are clearly documented.

### Action the hospital **SHOULD** take to improve

- Ensure there is a clear system in place which is understood by staff to monitor the application for Deprivation of Liberty Safeguards to track both the application and the expiry dates of any such applications to ensure patients are not unlawfully deprived of their liberty.
- Ensure the work to change control systems or the entrance and exit points of the unit, is completed in the agreed time scale.
- Review the security control measures in place for all the gates that lead from the inpatient ward garden area to help ensure it is safe place for patients to roam.
- Take action to ensure the conservatory is a safe area for patients to use when it is raining.
- Take account to ensure all staff are aware of the importance of closing and securing all doors assessed as needing to be shut for patient safety reasons.
- Implement a system to ensure the unit is secure and safe out of hours.
- Ensure staff are up to date with their mandatory training.
- Consider the introduction of clear guidance as to when a patient becomes a risk and the use of the tagging system should be used for their own safety.
- Ensure there is sufficient medical cover to provide a safe service.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

- Clear records of conversation with family members were not being maintained.

**Regulation 20 3 (e)**

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- A full assessment of environmental risk had not been conducted and patients were being placed at risk where risk were not being mitigated.
- Risk assessments were not being used to inform the planning of care to ensure patients care was planned in a safe way .

**Regulation 12 1, 2 (a) (b) (d)**

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

- There was a lack of evidence of completion of medical capacity assessments to inform the planning of care in the patient's best interest.
- Applications for the deprivation of a person's liberty were not considered when a patient was restrained through the use of bedside rails, mittens and intermittent one to one supervision.
- There was not a robust local system for the monitoring of both application and dates for DoLS.

This section is primarily information for the provider

# Requirement notices

## Regulation 13 5

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

- Patients were being placed at risk by the unsecure entry and exit points, which would enable some patients to leave the ward or the grounds unsupervised.

**Regulation 15 1 (b) (c) (d)**

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- There were not always sufficient staff with the right mix of skills and knowledge to meet the needs of the patients.

**Regulation 18 1**

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Records were found to be difficult to integrate, each patient did not have a contemporaneous record of care.

**Regulation 17 1, 2 (c)**