APPENDIX 1

Services	Crisis Service	Acute wards	Wards for older people	YCPM	LD wards	Forensics	CAMHS	SSLS	Provider
Detail of service	**Crisis Assessment Unit and Intensive Community services**	**Becklin centre ward 4 and PICU at Newsam Centre**	**The Mount**	**Yorkshire Centre for Psychological Medicine at the LGI site of LTHT**	**Parkside Lodge and Woodland Square at St. Mary's Hospital**	**Clifton House in York and wards 2&3 at the Newsam Centre**	**Tier 4 Child and Adolescent in-patient service at Mill Lodge in York**	**Specialist Supported Living Services based at St. Mary's Hospital**	**The Trust as a whole**
Required actions.									
Regulation 9: Person-centred care	Unit not being used for stated purpose of providing services of up to 72 hours.								
Regulation 10: Dignity and respect				Bedrooms not en-suite					YCPM did not comply with DH guidance for same sex accommodation
Regulation 12: Safe Care and Treatment					Patient care plans at 2 Woodlands did not show that staff had updated them.			There was not safe and proper management of medicines.	Emergency equipment and medication checks not robust on some wards. Medicines were not being stored at the correct temperatures. There was no physical health monitoring of antipsychotic medication. Staff in community services unclear who was responsible for physical health monitoring.

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Regulation 13: Safeguarding service users from abuse and improper treatment					The trust had not made Deprivation of Liberty Safeguards applications for patients at 2 and 3 Woodland Square.	Blanket restrictions were in place for routine searching following periods of leave	Staff did not have a full understanding of what constituted seclusion and the procedures to follow		
Regulation 17: Good governance	Service not fully completing section 136 detention documentation. Service did not routinely share all data with other agencies. CAS and intensive community service were not able to share relevant information with the Care Quality Commission in		The provider did not always maintain an accurate and contemporaneous record of each patient.					The system for reporting safeguarding concerns did not ensure all incidences were recorded robustly.	1.Governance systems to assess, monitor, and improve quality did not operate effectively 2.Trust did not have a systematic approach in place to assure themselves, that the directors met the fit and proper person requirement, 3. Incidents were not reported to the National Reporting and Learning

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	a timely manner.								System in a timely way. 4. Incidents were not reported in both the supported living service and the forensic and secure inpatient services in a timely way 5. Systems were either not in place or sufficiently robust to ensure that records were accurate and contemporaneous. 6. Internal audit systems were not always sufficiently robust to identify missed doses of medication 7. The application of the Metal Capacity Act in some services was not in line with the trust

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									policy or the Act. 8. Systems and guidance did not fully support the application of the Mental Health Act across the trust 9. Trust did not return data requested by the CQC during the inspection in a timely way.
Regulation 18: 2014 Staffing	Staff in the crisis assessment service and the intensive community service did not receive an annual appraisal.	The trust did not ensure that staff were up to date with their mandatory training	Not all staff had received appropriate training, supervision and appraisal	Compliance with mandatory training was low	The service did not offer staff regular supervision and annual appraisal.	Staff members were adequately trained in: Clinical risk Immediate life support Mental Health Act			Trust had not met its target of 90% compliance for appraisals. Trust compliance for clinical supervision was low across the trust.