Bigfoot Independent Hospital

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
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, and there remains a rating of inadequate overall or for any key question, we will take action in line with our enforcement procedures. At this point, we would begin the process of preventing the provider from operating the service. This will lead to cancelling the providers' registration at this service, or 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 Bigfoot Independent Hospital as inadequate because:

- There was poor governance in relation to the oversight of issues arising at the hospital and communication between the hospital management and the operational and board level.
- There was poor oversight and awareness of the Mental Health Act 1983 and the Deprivation of Liberty safeguards.
- The hospital was not managing medicines safely. We found several examples of dangerous medicines management including intramuscular medication given without a valid prescription, the wrong doses of medication given, patients being treated with high dose antipsychotic medication without additional monitoring, out of date medication and dressings and unsafe storage in the form of malfunctioning medicines fridges.
- We were concerned about staffing levels across the service, particularly within one ward with complex patients who required high levels of support. Staffing levels of qualified nursing staff were not safe. Qualified nurses on duty covered more than one ward, particularly during night shifts but also during the day.
- Staff did not receive the training required for their role. We found that staff had received basic one day training in learning disability, with no training in autism, communication needs and assessment, epilepsy or person centred planning.
- There was a lack of rehabilitative focus, with little evidence of discharge planning, little structured rehabilitative activity or assessment, poor access to psychological input and very little evidence of outcomes planning, monitoring or progress for patients. There were no links into community rehabilitative or structured resources or support to access these.

We raised our concerns about the quality of care being provided at the time of the inspection.

The provider took immediate steps to address shortfalls which included:

- extra senior management support
- an increase in staff,
- commissioned an independent review of all detention papers,
- an investigation into the detention errors and addressing the issue of informing patients and relatives
- changing provision of pharmacy support.

We also shared our concerns with the commissioners of the service. We have taken enforcement action and we will be working with the provider to ensure that improvements are made.

Summary of findings

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Inadequate

Bigfoot Independent Hospital

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to Bigfoot Independent Hospital

Bigfoot independent hospital provided care and treatment for up to 28 male patients with a primary diagnosis of learning disability or autism.

It was registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

There were five wards at the hospital; on the ground floor there was Da-Vinci ward which had six beds and Dali ward which had six beds. On the first floor there was Picasso ward which had six beds and Monet ward which had six beds. On the second floor was Matisse ward, which had four beds.

At the time of inspection, there were 22 patients resident within the service. One patient was detained under a deprivation of liberty emergency authorisation, with all other patients detained under the Mental Health Act.

The hospital has been registered with CQC since 04 January 2011. There have been six inspections carried out at this service. The most recent inspection was conducted on 3 December 2013 and the hospital was found to be compliant with standards at that time.

At the time of this inspection, the service had a registered manager and a controlled drugs accountable officer.

Our inspection team

Team leader: Andrea Tipping

The team that inspected the service comprised three CQC inspectors and three specialists with experience of services for people with learning disabilities: a chartered psychologist, a clinical pharmacist and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at a focus group and individual interviews.

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;

Summary of this inspection

- spoke with 11 patients who were using the service and collected feedback from 12 patients using comment cards;
- spoke to three carers of patients and collected feedback from five carers using comment cards;
- spoke with the registered manager, general manager and clinical nurse lead;
- spoke with 11 other staff members; including doctors, nurses and the psychologist;
- received feedback about the service from commissioners;
- spoke with an independent advocate;
- attended and observed two hand-over meetings and one morning planning meeting;
- looked at 10 care and treatment records of patients;
- carried out a specific check of the medication management on all five wards;
- observed a medicines administration round on DaVinci ward;
- examined in detail the legal files of five patients;
- spoke with the Mental Health Act administrator;
- undertook a short observational framework (SOFI) assessment on Matisse ward;
- spoke with the nominated individual, the head of commissioning and the operational manager; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We received variable feedback from patients and carers about the service. Patients felt they were not involved in care planning and were unclear about their pathway in terms of discharge.

Some carers spoke positively of the service, feeling staff treated their relatives with dignity and respect. Other carers were concerned about the treatment of their relatives and described poor communication with the service.

We asked for feedback from a wide range of other agencies prior to inspection. Commissioners gave variable feedback, one describing poor communication in terms of care programme approach (CPA) meetings and concerns that outcomes from care and treatment reviews (CTR) were not being actioned. Lead commissioners had undertaken a quality improvement plan with the hospital in recent months and felt the service was making good progress.

We asked the hospital to tell us about the community resources that patients used so we could ask them their view of the hospital. We contacted nine community resources but only received feedback from one, indicating that there had been no patients from the hospital using the service for several years.

There was one feedback account on the Share Your Experience website left in August 2015. Issues raised included communication difficulties, chaotic meeting arrangements, concerns about information governance, allegations that staff shout at patients and then positive feedback about some staff who the commenter felt provided good care.

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:

- There were ligature points throughout the building which staff were not aware of with no mitigation planning. There were environmental hazards in terms of floor and wall coverings not being safe and equipment was not always well maintained.
- There were too few qualified nurses to meet the needs of the patient group adequately.This was particularly so at night. Patients and staff reported leave being cancelled due to low staffing levels and clinical observations were not being recorded as per the hospital policy.
- Staff did not complete risk assessments fully or review them regularly.
- There were blanket restrictions in place regarding kitchen and cutlery access.
- Medicines management concerns included a medicine which was prescribed to be given in tablet form was given as an injection, medicines being used for patients were found to be out of date and two fridges containing medicines were not maintaining temperature correctly. Sharps and medicines disposal bins were not available in every clinic room. Five patients were prescribed high doses of antipsychotic medication without this being identified and there were no monitoring guidelines for high dose antipsychotic treatment. There were no monitoring guidelines for rapid tranquillisation.
- There were no systems for incident review and disseminating lessons learnt.

However:

- Resuscitation equipment was checked regularly and stored accessibly for use in an emergency.
- Staff were aware of and complied with incident reporting.

Are services effective?

Inadequate

We rated effective as **inadequate** because:

- Documentation was poor.Staff had not fully completed some comprehensive assessment formsor and health action plans.Physical health information was not available to review and there were concerns that essential background information had not been requested.

Summary of this inspection

- Patients were not involved in care planning and care planning did not reference or reflect best practice guidance. Staff did not undertake speech and language assessments to inform care planning. Staff did not use positive behavioural support plans.
- There was no evidence of discharge planning and staff did not use outcome measures.
- Patients had limited access to psychology provision.
- The service did not offer its staff training in autism and meeting of communication needs.
- There were instances where patients were detained without this being legally authorised and there was poor oversight of both the Mental Health Act and Deprivation of Liberty Safeguards authorisations. Managers renewal hearings were not taking place at the time of section renewals. Patients were not read their rights in accordance with the Mental Health Act.

However:

- All patients were registered with local GP practices and encouraged to attend the practice.
- Staff were receiving regular supervision.
- There was good, well supported independent advocacy provision in place.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- Poor interactions were observed with patients with complex needs and presentations within Matisse ward.
- Patients reported a lack of direction and no planning towards discharge and they reported not being involved in care planning.
- Some interactions which did not recognise a right to privacy and dignity were observed, for example, entering patients rooms without knocking.
- Some carers reported poor communication.
- Patients reported staff speaking in other languages in communal areas of the ward or using mobile phones on duty.
- There was little evidence of patient involvement in the running of the service.

However:

- We saw many instances of positive, caring interactions between patients and staff on Dali, Da-Vinci, Picasso and Monet wards.
- Staff clearly knew patients well.

Summary of this inspection

- Some carers reported feeling their relatives were treated with dignity and respect and received good care.

Are services responsive?

Inadequate

We rated responsive as **inadequate** because:

- There had been no consideration given to environmental factors which impacted on patients with autism.For example, alarms sounded throughout the building when doors were left open for longer than 10 seconds.
- There was little evidence of discharge planning in files.
- In terms of facilities, there was no clinic room with an examination couch available in the hospital. There were no private telephone facilities for patients.
- Staff, patients and visitors could only gain access to two of the wards, Dali and Picasso, by walking through the bedroom corridors of adjoining wards.
- Occupational therapy activities were mainly group activities, with little rehabilitation focus and there were no activities at weekend. There was little evidence of nurse led or ward based activities
- Section 17 leave was often of short duration with little planned rehabilitation purpose
- Information was not available across the service in easy read or pictorial format and there were no communication assessments or plans
- Staff and patients were unaware of the complaints procedure

However:

- There were quiet lounges on each of the wards.
- There was access to outside spaces in the form of several small garden areas.

Some wards had information boards displaying easy read information.

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

- There was not sufficient oversight or monitoring of the Mental Health Act or Deprivation of Liberty Safeguards and there was not sufficient oversight or monitoring of medicines management.

Summary of this inspection

- Where issues were identified locally, such as unlawful detention, staff had not escalated these to the provider's senior management team.The risk register was not up to date or accurate and items had been removed with no assurance these were no longer risks.
- Organisational policies did not reflect changes in legislation or good practice guidance.
- Staff survey results suggest a lack of team work and that team performance had declined. Staff meetings did not occur every month and few staff attended these.
- There were no developmental opportunities for staff.
- Information from investigations and lessons learnt was not disseminated to staff and at the time of inspection there was no policy or procedure in place acknowledging the Duty of Candour.
- The service did not participate in national accreditation schemes or in other national quality assurance schemes.

However:

- Human resources procedures were thorough and correctly followed.
- The fit and proper person regulations were being followed.

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.

During this inspection, we found evidence of poor adherence to and oversight of the Mental Health Act 1983.

We found instances were sections had lapsed and patients had been subject to detention without this being legally authorised.

Staff did not read the rights to patients at timely intervals. Information regarding patients' rights was not always available in easy read format.

We found one instance of a patient who had leave from the hospital with no section 17 leave authorisation in place.

Manager's hearings had not been taking place at the time of section renewals.

Mental Health Act monitoring visits have taken place regularly. Recurrent themes across the service include:

- Disorganised case files with missing or incomplete information
- Incomplete "All about me" forms, including missing and out of date forms
- Incomplete or missing CPA documentation and poorly completed meeting minutes
- Incomplete, poorly completed or missing Health Action Plans including undated forms
- Little evidence of patient involvement in care planning or positive support plans
- Little evidence of discharge planning
- Section 17 forms not routinely given to patients/carers including poorly completed "Moving on" assessments

Additionally, the following issues have been reported

- Activity plans and on ward activities, including evidence that patients were taking part in any planned activities and a lack of ward based activities (Picasso)
- Staff and patients reported reduced psychology and locum OT input (Picasso).
- Environment (Picasso – stained carpet, curtains missing, light bulbs not working, broken furniture)(Dali – broken furniture, broken communal toilet)(Monet – communal bath and toilet broken).
- Community meeting minutes missing and no follow up actions (Picasso).
- Communication within hospital (Picasso) regarding a patient whose section lapsed.
- No easy read care plan format (Dali).
- Reports of staff talking to each other frequently in another language (Da Vinci).
- No easy read activity planners (Da Vinci).
- Physical health assessment at admission not consistently recorded (Dali).
- Capacity assessments not reviewed regularly (Da Vinci).
- Two medications not authorised under T3 being given (Monet).

Mental Capacity Act and Deprivation of Liberty Safeguards

During this inspection, we found evidence of poor understanding and oversight of the Deprivation of Liberty Safeguards (DoLs).

There were instances where emergency authorisations had been sought and then not renewed. When a best interest assessor had refused to authorise a DOLs application no further action had taken place and the patient had been subject to detention without this being legally authorised . We found an instance where a DoLs authorisation had been granted and then allowed to lapse before an application was made to renew some two months later again resulting in the patient being detained without this being legally authorised .

We saw evidence of mental capacity assessments in patients' records.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate

Notes

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

There were five wards at the hospital, two on the ground floor, two on the first floor and one on the second floor. All wards were set out on a series of corridors, with line of sight observation difficult, although mitigated in corridors by the use of parabolic mirrors.

There were ligature points in the form of taps, window closures and door fittings. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The registered manager completed an annual ligature point audit. However, this was not available on the wards. Staff on the wards did not know what ligature points there were on the wards they were working on and how the risks of these should be managed. The ligature audit had been last completed in October 2015. It included obvious ligature points such as door closures, but not low level ligature points. We found some of the plans to reduce the risk of these points were not being routinely followed, for example the audit suggested that bathrooms would always be locked as the taps had been identified as ligature points, but we noted unlocked bathrooms on wards.

All four clinic rooms were seen. They were generally tidy. The resuscitation equipment was stored centrally on Picasso ward, and was checked regularly. There were notices on other wards to ensure staff knew where this equipment was. The resuscitation equipment used to be stored in one of the clinics but this was now stored in the office to ensure it was available quickly for use in an emergency. Ligature cutters were stored in clinic rooms.

Ward communal areas were generally clean, although there was some furniture which was worn. We were told there were plans to replace these in the near future. On DaVinci ward, in two en suite bathrooms, tiles were coming away from the wall. On Monet ward, in one en suite bathroom, tiles were coming away from the wall. Similarly, in a bathroom, there was linoleum coming away from the floor which could present a trip hazard. The communal areas on Monet ward were not well maintained, with stains on the ceiling in both the lounge and quiet room. Cleaning records were up to date and we saw cleaning staff undertaking tasks as per the records.

There was adherence to infection control principles, with gloves and aprons available for clinical use. Antimicrobial hand wash was available in wall dispensers throughout the service, however we did not see this being used routinely. During mealtimes, staff wore appropriate aprons and hair coverings.

Staff did not maintain all equipment well. For example, two of the clinic room fridges were malfunctioning and not maintaining the correct temperature.

Staff undertook environmental risk assessments were undertaken, but we did not see clear evidence that they always took the actions identified. For example, some of the issues noted in November 2015 in terms of the outside spaces, storage and bedrooms were still present.

There was access to alarm systems. Staff used portable alarms to alert staff to incidents.

Inadequate

Wards for people with learning disabilities or autism

Safe staffing

The service reported that during the 12 months of 2015, there were 12 substantive staff leavers, which was reported to be 12% of the overall staffing. Clarification of these figures was requested as this would appear to suggest there are 100 staff employed at the hospital, however this has not been received. The vacancy rate was reported as 3%. Overall sickness was at 4% overall.

There were not always enough suitably qualified staff to look after patients safely. There was a minimum staffing ratio of one qualified nurse and three support workers to each day shift on Monet, Picasso, DaVinci and Dali wards. We reviewed the last six weeks of duty rotas. This showed that on average at least three 12 hour day shifts per week were unfilled by qualified staff meaning that one qualified nurse covered two wards.

At the time of inspection, one qualified nurse covered the three upstairs wards (Matisse, Picasso and Monet) at night and one qualified nurse covered the two downstairs wards (DaVinci and Dali) along with support workers for each ward. There were only three registered nurses, who were substantively employed by the provider, rostered to cover night shifts across the whole hospital. One of these nurses was a registered general nurse (RGN), rather than a registered mental nurse (RMN) or registered nurse for learning disability (RNLD). On two occasions, the only regular nurse on duty was the RGN, so in effect the detention of 22 patients in the hospital was dependent on one RMN, who worked for an agency. On examining the last six weeks of duty rotas, there were several occasions each week where qualified cover at night was one RMN or RNLD and an RGN. This meant that for across all five wards there was only one nurse with learning disability or mental health training. An RGN does not have specialist training in learning disability or mental health.

Matisse ward was a four bedroomed ward on the second floor of the hospital. Prior to September 2015 this ward had not been used and was described in the statement of purpose as a step down unit preparing patients for discharge. The ward had been opened as a low stimulation area for two patients who had been admitted in crisis and who were expected to only be at the hospital a short time whilst alternative accommodation could be found.

At the time of this inspection, Matisse ward was still open and had two complex patients who could become quite agitated at times and had communication difficulties. The staffing level was two support workers with no qualified nurse. There was not a specific staff team for Matisse ward and support staff were allocated from other wards to cover. Sometimes staff allocated were agency staff. There was then an hour's support provided from Monet and Picasso ward qualified staff (which included medication administration) and we were told the general manager or clinical nurse manager spent additional time there during the day. We felt that this level of staffing, particularly in terms of skill mix and clinical leadership, was not sufficient given the needs of these two patients. For example, for both patients, medication which had been prescribed had not been ordered. Keyworkers were allocated from other wards and keyworker sessions were not occurring regularly. Clinical records for both patients were kept on other wards. We carried out a short observation framework on Matisse ward and saw an incident that was not witnessed by staff and staff interactions which showed a lack of understanding of autism and of the needs of the two individuals in terms of space and noise. We raised this as a concern during the inspection and a qualified nurse was immediately rostered to be on duty on Matisse ward every shift, day and night.

We were told that staffing levels were increased above these levels when needed to cover increased observation levels.

There was a high level of bank and agency use, primarily support worker cover. This averaged 877 hours per week, or over 60 x 12 hour shifts filled with temporary staff.

For example, on one week in February 2016, regular staff shifts on the duty rota totalled 141 shifts, with an additional 34 shifts worked by permanent staff as overtime or bank work and over 72 full shifts covered with bank/agency staff.

Many regular staff worked additional hours at the hospital with duty sheets showing staff regularly working one or two additional shifts each week. Agency nurses were often block booked to ensure continuity and had to have an induction before they could work on the wards.

During this inspection, qualified nurses tended to focus on task driven activity. The allocation sheets showed that for the most part planned activity by qualified staff focussed on medication rounds and updating case files, with case

file reviews often booked in for four or more hours during the day. This meant that for patients there was less access to qualified nurses and no planned activity or contact with patients.

The lack of staff was impacting on patients' care. Staff and patients told us that escorted leave and ward activities were sometimes cancelled because of staffing numbers. There was no specific monitoring to check how often this was occurring. Staff told us that when leave was cancelled due to staffing this was documented in the patient notes. Planned escorted leave was often for an hour's duration and to the local area shops despite having section 17 leave authorised for longer periods. Patients had complained that leave often felt rushed, as they had to return within an hour. Allocation sheets showed that patients leave was often timetabled for an hour between periods of staff undertaking observations.

The medical cover in to the hospital was provided by two psychiatrists who each worked one day a week at the service. Out of hours, there was a rota for several services with medical staff familiar with the service available. There was also out of hours GP provision although staff told us the first contact tended to be to the out of hours psychiatrist.

Staff completed mandatory training at induction and every year post induction. As of April 2016 most mandatory training was above 80% of total staff. Learning disability awareness training attendance was recorded for 62% of nursing staff and 79% of staff had attended observations awareness training at the end of December 2015.

Assessing and managing risk to patients and staff

There was no seclusion facility at this hospital. There had been no use of long-term segregation. There were six incidents of restraint reported across all wards in the six months leading up to December 2015. None of these were incidents of prone restraint and the six incidents involved four service users. There had been one incident of prone restraint in February 2016.

We looked at nine clinical record files. The risk assessment tool in use was the individual risk mitigation process devised for use at another learning disability hospital. Staff had completed risk assessments in the majority of the files we examined, but none were up to date or fully completed. In one file, the patient has been resident for over six months but the only risk assessment available was from the previous provider. For one patient who had been re-admitted from a community setting, there was no up to date risk assessment available. Another case file contained a historical clinical risk assessment, which appeared to have been completed prior to admission in 2014.

Blanket restrictions were in place in all of the wards, for example, staff locked most kitchens. Patients needed to ask staff to access the kitchens to make drinks and staff locked cutlery away in the kitchen and only used at mealtimes. On one ward, crockery and cups were all strengthened plastic. However we also saw that some activities were individually risk assessed. For example, some patients had access to their own mobile phones and two patients had internet-enabled tablets. One patient had a swipe card to enable him to access the garden area without staff supervision.

Many patients throughout the hospital were nursed on enhanced observations. This was either level 2, every 15 minutes or level 3, continuous. Staff were not always clear why a patient required enhanced observations and reading the observation records what was often recorded was information about the physical location of the patient rather than observations about mood or mental state. Staff told us observation levels were reviewed in the multidisciplinary team meetings but the records of these meetings did not include information on this. On Monet ward, we noted five patients were subject to level 2 observations and one patient to level 3 observations. On reviewing the records for March 2016 there were frequent blank spaces in the written records. On some days, this amounted to three to four hours with nothing recorded. The observation policy makes clear that staff completing observations should complete a written record at the time of undertaking observations.

A patient subject to observations told us that staff would not engage in activities with him, for example, requests to play board games, as this was not the purpose of observations. This did not fit with the observation policy which identified staff should be encouraging therapeutic trust.

The hospital provided team-teach training which teaches restraint techniques but also focusses extensively on de-escalation strategies. We saw that staff knew patients within their care well and would try to de-escalate or resolve situations without the use of restraint. Most patients had a positive handling plan in place, which was a

short form which had tick boxes for strategies in certain situations but mainly focussed on team teach techniques. However there was little additional detail for staff to follow and enable staff to understand effective strategies and there were no comprehensive positive behavioural support plans in use in the service. This meant that staff who were not familiar with the patient would not have sufficient information to enable them to respond appropriately.

Rapid tranquillisation was rarely used within this service. We examined one incident of rapid tranquillisation that took place this year. Staff had given a patient intramuscular medication whilst under prone restraint. The patient was not prescribed this medication to be given intramuscularly, only orally. There had been one set of physical observations documented in the incident form, although it was not clear when these were taken. There was no further monitoring documented in the clinical notes. The medication policy did not have a rapid tranquillisation section. This meant that there was a risk that patients would not be monitored for potential side effects of medicines. This incident was being investigated and following this inspection a safeguarding referral was made. Following the safeguarding referral we were provided with rapid tranquillisation guidelines which were not up to date with current practice and overdue for review. Staff that we spoke to and clinical records did not refer to these.

Staff we spoke with had a basic understanding of safeguarding in terms of physical abuse, although none spoke of other forms of abuse, which may affect vulnerable patients. All staff were aware of referral pathways.

There were serious concerns raised in relation to medicines management. The hospital was not managing medicines safely.

Sharps bins were not present in all clinics. This had been identified as an action by the commissioners following a visit in December and had been rectified at that time. We found a medicines disposal bin contained sharps in one clinic. We immediately brought this to the attention of staff, who then placed a sharps bin in the clinic and locked the disposal bin and removed it. Medicines disposal bins were not in place in all clinics and on one ward a sharps bin was being used to dispose of medication.

There was one ward with a disposal log to show when medication had been disposed of and there were different methods of disposing of medication on the wards.

We found two fridges to be faulty and both contained medicines. One was recording high temperatures and the other one was recording low temperatures, at times below freezing. Staff had been monitoring and recording fridge temperatures, however, they had not taken any action. We found one medication fridge was unlocked which contained medication.

The GP service prescribed medicines using outpatient FP10 prescriptions. FP10 prescriptions are commonly used by community GPs rather than hospital prescriptions. A copy of the prescription was supplied with stock from the chemist. Medication was then administered from a prescription record kept up to date by medical staff. We found numerous instances where medical staff made dose changes to the administration card but had not communicated this to the GP. This meant that the boxed supply labels gave different doses or frequencies than the administration card. In one instance, a prescribing error on the administration card had not been reported. Medication had been prescribed with the wrong dose written at night. The correct dose tablets were available and nursing staff confirmed the correct dose was being given.

Medicines were not being ordered in a timely fashion when medication doses were changed or new prescriptions started. A patient on Matisse ward had been prescribed as needed medication but this had not been ordered and was not available. We saw an FP10 from the dentist for antibiotics in a patient file from a visit seven days previously but no evidence that staff had requested the medicine for the patient and no corresponding entry on the administration card.

We found two boxes of out of date medicines, which staff were still administering. These had both expired in 2015. We also found dressings and first aid supplies, which were out of date.

On checking stock levels with medicines used, we discovered a number of tablets from one supply were missing and unaccounted for.

Staff had given one patient a higher dose of as needed medication than was prescribed to one patient on three occasions.

One patient was prescribed an injection, which was one week overdue at the time of this inspection. Staff told us that this was given at the GP surgery but it was unclear whether the patient had attended for this.

Inadequate

Wards for people with learning disabilities or autism

Five patients were prescribed medication above the British National Formulary (BNF) limit. The BNF is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing. This was for antipsychotic medication but not identified as such or monitored by the hospital. High dose antipsychotic treatment requires additional monitoring and patients who are treated with higher doses should be identified as such and a plan in place for monitoring. There was no guidance in the medicines policy for this.

One patient was prescribed medication which was not included on his T2 consent to treatment form but it had been administered 13 times.

Track record on safety

There had been five serious untoward incidents in the last twelve months. These have all been patients going absent without leave. Three of these incidents involved the same patient. These three involved climbing over a fence on one occasion and on two occasions escaping from the building. We asked for the investigation reports for these but these were not provided.

The incident this year involved a patient breaking open a fire door and gaining access to the reception area where a member of non-clinical staff let the patient leave the hospital.

Reporting incidents and learning from when things go wrong

All staff were aware of the procedure for reporting incidents and how to complete an incident form. Nurses completed incident forms and we saw examples of these in case records.

Incident reports were not scrutinised regularly to identify themes or patterns. Whilst investigations had been completed for the serious untoward incidents, learning from this was not then communicated to staff in terms of learning. For example, in terms of the patient who had absconded several times, there was no evidence in the clinical records of the serious incident reviews, lessons learnt or any process relating to staff reviewing risks.

Staff told us that debriefs took place following incidents and that there was adequate support.

Duty of Candour

When things went wrong, we did not find that the hospital informed patients or carers or that there was a culture of openness and transparency.

At the time of inspection, there was no duty of candour policy. A comprehensive duty of candour and being open policy has since been formulated and distributed.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

We reviewed nine case records. There was a comprehensive assessment form in four of the records, which provided information across a wide range of domains. The hospital had changed the format for care records, and the records within the newer format were easier to find information in. However, there were still a number of blank or partially completed documents. Health action plans were found in four of the records examined. We found that for one patient with ongoing physical health concerns there had been no attempt to acquire previous records relating to physical health history, which meant that even though the health action passport was completed it lacked relevant historical detail. The medical history section contained a psychiatric history.

Physical health care and examination was undertaken by the patient's GP. There was reference in the clinical notes to GP visits but the notes of the consultations, examinations (including annual health checks), investigations and results were contained within the GP practice records, which staff had no access to. This posed a risk to patients that information may not be available about their physical health conditions in an emergency. We were also unable to see records relating to ongoing chronic disease management and review, for example, for patients with diabetes.

In the case notes we reviewed, care plans had been completed. There was little evidence of patient involvement in these, with only one set of care plans signed by the patient.

Care plans were not recovery focussed and a common theme was a lack of any formulation or sense of direction, outcomes or discharge planning in any of the files we reviewed.

There were no care plans or direction in terms of patient observations and this posed a risk to patients and staff. It was not clear what the risks were and what behaviours/ changes staff were expected to observe for.

There were no positive behavioural support plans in use in this service. Psychology staff told us that they viewed the positive handling plan as the format for positive behavioural support and so had not felt it necessary to implement behavioural support plans. However, the positive handling plans were generally a checklist of team-teach techniques with tick boxes, and in the examples we saw there was limited or no additional information added to the ticks. This was not felt to be adequate in terms of positive behavioural support planning. Staff did have good de-escalation skills and knowledge of patients on most of the wards during this inspection but strategies were not effectively described in the records.

Care records were held as paper files. The GP records were held elsewhere and not accessible to the hospital staff. Psychology records were also held separately and did not form part of the main clinical record. We did not see psychology notes or reports in the clinical records reviewed.

Best practice in treatment and care

We did not find evidence that staff were considering National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. We found evidence of prescribing with out of date maximum British national formulary limits for one antipsychotic. NICE guidance in relation to the care of adults with autism and the care of patients with a learning disability and challenging behaviour was also not followed in relation to care planning.

Psychological interventions were not readily available. An assistant psychologist (psychology assistants are commonly psychology graduates working under supervision to gain clinical experience) undertook the psychological assessment/intervention work in the hospital. The assistant psychologist was available for two days a week. They were supervised by a consultant clinical psychologist who worked one day a week for the provider group. We were told by the consultant clinical psychologist that psychology staff undertook functional analysis to provide support for nursing staff in managing behaviour. We saw completed assessment forms by nursing staff in records but did not see a psychologically informed functional analysis report. We asked to see an example but one could not be located. Psychology staff told us they had no time available to undertake training, peer supervision or other functions, which would help to support care. We saw no evidence of psychology input, either individual or in terms of ward round summaries, in the records we reviewed. We were told this was because psychology case notes were held separately. Referrals for psychology input were made by the responsible clinician meaning that not all patients had access to psychology services.

Access to physical healthcare was generally via the GP service. Patients were registered with one of three local GP practices. Home visits could be arranged if needed although most patients were seen at the practice. There was regular liaison with the GP service that had most patients registered. The notes from GP consultations were held within the GP records and no copies were available in the hospital notes.

A speech and language therapist visited the service on a sessional basis. We saw evidence in one person's case record of a detailed assessment, with an identified risk of choking and strategies to try to minimise the risk of this. These strategies had not been incorporated into a care plan for staff to follow and the case notes were stored on a different ward to the ward he was residing in. Support workers on the ward were not aware of these strategies.

A physiotherapist had been involved in liaising with the service for a patient with mobility issues. Equipment was available including a mobile hoist and a height adjustable bed.

We saw no use of outcome measures in use at this service. This meant that progress was not being objectively measured during admission.

We saw little evidence of clinical audit being used to measure quality and improve standards. There was a full programme of local audits but we were not assured of the robustness of these in terms of identifying issues, for example, in terms of medicines management or audit of the Mental Health Act. An audit of medicines management

had been completed the week before inspection by the pharmacy provider with no problems identified. The Mental Health Act audit was completed annually and sampled two records from those available. There was no participation in national audit.

The service was not accredited with any national quality programmes, for example, Accreditation of Inpatient Mental Health services (AIMS).

Skilled staff to deliver care

Multidisciplinary team care was comprised of medical, occupational therapy, psychology and nursing staff.

There were two doctors at Bigfoot who each worked one day a week on site.

There was limited resource in terms of psychological interventions with clinical work undertaken by an assistant psychologist who worked two days per week.

A full time occupational therapist provided group and individual interventions and was assisted by two occupational therapy assistants.

There was no access to a clinical pharmacist. The provider had a contract with a local pharmacy to provide supply of medicines and clinic audits.

Staff told us they received regular supervision and there was a system in place to record this. We saw supervision files, which confirmed staff received regular supervision.

The current annual appraisal rate as at April 2016 was 84% of non-medical clinical staff who had had an appraisal. Both doctors had been revalidated.

When staff commenced employment there was a one-day session as part of this entitled “Introduction to Learning Disability” and taught by the registered manager. We noted in one of the training audits that this session was titled Learning Disability/Mental Health/Dementia awareness, suggesting that this session was not wholly related to learning disability despite being only one day’s training and the only learning disability training available.

Staff we spoke to felt they needed more training in learning disability, autism and mental health. Staff had raised this in minutes of a staff meeting in October 2015 and it was noted at the time that this was being arranged, along with physical health training, but this had not occurred by the time of this inspection. The National Institute for Health and Care Excellence (NICE) Autism in adults: diagnosis and management guideline recommends that staff working with people with autism have training in the nature and development of autism, impact on functioning and awareness of environmental factors.

There was no training available regarding communication needs, despite some patients having little verbal communication skills or having used adaptive methods of communication previously. There was also no training available in person centred planning or positive behavioural support, although training in person centred planning was planned for the future.

Nursing staff said they received a comprehensive induction and then worked on the ward shadowing a mentor before they started to work substantive shifts. The hospital supported support workers to undertake the care certificate.

The operational manager outlined plans and dates for “defensible documentation” and “person centred planning” sessions in the near future.

We reviewed personnel files and found these to be comprehensive and well maintained.

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings were often attended only by nursing and medical staff. Whilst there was a summary on the recording sheet for other disciplines, this was often blank. Occupational therapy input was summarised from the clinical notes but psychology input could not be summarised this way, as they did not record within the patients care records.

Care programme approach meetings had dates changed frequently, we were told this was often to ensure attendance of care co-ordinators.

Adherence to the MHA and the MHA Code of Practice

We found poor practice in the use of the MHA and Code of Practice.

We reviewed the legal files for five patients during this inspection. Of these, four contained evidence of periods of detention without this being legally authorised , whereby the patient was not subject to detention under the Mental

Health Act or subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. The patients had not been aware of this, had not been allowed to leave and had continued to be given treatment.

In one case, the patient was admitted under section 2 of the Mental Health Act. This had lapsed after admission, with a one week gap before an emergency DoLS authorisation was made. This then lapsed with a further week where there was no lawful detention in place. The Best Interest assessor then saw the patient and their report showed that they had refused to authorise a Deprivation of Liberty and had advised that the route for detention was to assess for a section under the Mental Health Act. Despite this, a further ten weeks passed before a Mental Health Act assessment took place and an application was made for detention under section 3. A further DoLS urgent authorisation was completed in the middle of this 10 weeks, despite the DoLS application having already been refused.

Another patient had gaps in detention altogether totalling just over 11 weeks. He had previously been detained on section 2 which expired. A DoLS urgent application was made on the same date, which expired a week later. Two weeks passed before a standard authorisation under DoLS was granted, so there was a period of two weeks where the patient was detained without this being legally authorised . When the authorisation expired there was nothing in place for nine weeks when a standard authorisation was applied for, with an urgent authorisation also completed. This patient was discharged from hospital prior to the assessment being completed for a DoLS authorisation.

In the third instance we identified gaps altogether of just over 5 weeks. The patient had been detained under section 3 which expired. A period of four weeks passed where the patient was detained without this being legally authorised. A section 5(2) (a doctor's holding power) was then completed which expired with no further action. Four days later an urgent DoLS authorisation was completed which then expired. Six days after this a further section 5(2) was completed and converted to section 3.

The fourth patient had gaps in detention altogether totalling two weeks. He was admitted under section 2 of the Mental Health Act. When this ended, an emergency DOLs authorisation was made but then not renewed. A further two weeks passed before he was detained on section 5(2) and then section 3.

At the time of the inspection, all four patients were detained under suitable legal authorisation under the Mental Health Act or DoLS.

The hospital had not informed the four patients or their nearest relatives of the errors, despite the registered manager and clinical nurse manager being aware of the mistakes.

The registered manager was aware of the two instances where patients had been detained without this being legally authorised, but had failed to take timely action. In one case, the best interest assessor report showed that they had refused to authorise a Deprivation of Liberty and had advised that the route for detention was to assess for a section under the Mental Health Act. Despite this, a further ten weeks elapsed before a Mental Health Act assessment was undertaken. We were told this was because an appeal was being considered against the decision by the best interest assessor despite there being no provision for this in the Deprivation of Liberty safeguards code of practice. We found no evidence that such an appeal or request to reconsider was made.

The responsible clinician said they were unaware of the periods of detention without legal authorisation.

We found poor practice in terms of the informing patients of their rights under the Act, with one patient having been detained for five weeks before his rights were initially explained, another patient had rights explained ten days after the section started and for a patient admitted under section 2 we found no evidence that his rights were explained for the duration of the section. We also saw section 132 forms noting that a patient had not understood their rights and that further attempts should not be made. We found limited use of easy read rights leaflets or creative attempts to ensure patients understood their rights.

Manager's hearings had not been taking place at the time of renewal of sections with a wait of between four to five months reported.

Section 17 leave authorisations were in place for patients and completed fully. However, in one case a patient had been using leave for two weeks without a leave authorisation in place.

Mental Health Act policies did not reference the current Mental Health Act Code of Practice 2015.

Inadequate

Wards for people with learning disabilities or autism

The hospital had employed a new Mental Health Act administrator in September 2015. They had limited training to undertake this role. The administrator had no training in Deprivation of Liberty safeguards.

The nominated individual undertook annual audits along with the Mental Health Act administrator. Items checked included section papers, consent to treatment status and reviews, contact with nearest relative, reviews and hearings and section 17 authorisations. At the most recent audit in December 2015, two patient's case and legal files were checked. These were thoroughly checked with the audit noting issues with section 61 records which had not been sent, capacity guidance not being fully followed, an older format of section 17 forms being used, nearest relative not being informed of when rights have been explained and no evidence of section 17 forms being copied to patients.

An independent audit of all legal files had started immediately before this inspection but most files had not yet been audited.The provider had good access to independent mental health advocacy (IMHA) services and the IMHA chaired patient meetings. The IMHA had also been involved in a food survey in 2015.

Staff attendance at Mental Health Act training was 89% of clinical staff at the time of inspection.

Good practice in applying the MCA

Eighty-five percent of clinical staff had attended Mental Capacity Act training and training in the use of Deprivation of Liberty safeguards as at December 2015. Staff were able to describe the purpose of the Mental Capacity Act.

Within care files, there was evidence of some capacity assessments, however, these were often not detailed enough in terms of the specific decision being considered. In one CPA meeting there was a scenario discussed which should have triggered a capacity assessment but records did not show that this was considered.

We did not see any best interests meeting minutes.

We were concerned that staff were not clear about when to use the MCA and when to use the MHA. They also demonstrated little understanding of the concept of least restrictive intervention.

The hospital managers had demonstrated poor understanding of the Deprivation of Liberty safeguards (DoLs) in terms of emergency applications which were not renewed and authorisations refused with no immediate follow up action. We noted this in four instances.

In one case an emergency DoLS authorisation was made. This then lapsed with a further week where there was no lawful detention in place. The Best Interest assessor then saw the patient and their report showed that they had refused to authorise a Deprivation of Liberty and had advised that the route for detention was to assess for a section under the Mental Health Act. Despite this, a further ten weeks passed before a Mental Health Act assessment took place and an application was made for detention under section 3. A further DoLS urgent authorisation was completed in the middle of this 10 weeks, despite the DoLS application having already been refused.

For a second patient, a DoLS urgent application was made which expired a week later. Two weeks passed before a standard authorisation under DoLS was granted, so there was a period of two weeks where the patient was detained without this being legally authorised. When the authorisation expired there was nothing in place for nine weeks when a standard authorisation was applied for, with an urgent authorisation also completed. This patient was discharged from hospital prior to the assessment being completed for a DoLS authorisation.

In the third instance we noted that an urgent DoLS authorisation was completed which then expired. Six days after this a further section 5(2) was completed and converted to section 3.

In the fourth case, an emergency DOLs authorisation was made but then not renewed. A further two weeks passed before the patient was detained on section 5(2) and then section 3.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, dignity, respect and support

On the majority of the wards, we witnessed positive and respectful interactions between staff and patients. It was

clear that staff knew patients well. On Monet and DaVinci wards, staff were working with complex groups of patients with widely differing needs and worked well with this. On Dali and Picasso wards, warm and humorous interactions were seen between patients and staff.

On Matisse ward, we observed poor interactions, including loudly voiced instructions to a patient and staff speaking about the patient in a negative way in their presence. Staff appeared to have a limited understanding of autism and how best to support patients with complex needs. Staff were not aware of the impact of the environment on individuals including loud noises and the impact bright lighting may have on patients with autism.

We observed staff enter a patient's bedroom without knocking or asking, and two patients (on different wards) told us this happened regularly to them.

We spoke to 11 patients using the service and received an additional 12 comment cards from patients. Patients described feeling a lack of direction and no planning towards discharge. One patient was unsure of why he was in hospital. Another patient was aware of his discharge plan and pathway.

The involvement of people in the care they receive

Managers told us that admission booklets were available, however, patients told us they had not received these. We did not see admission booklets during this visit. They told us that staff had orientated them to the ward when they had first been admitted.

None of the patients said they had been involved in care planning. One patient told us he could not read so care plans were read out to him, but he was not involved in contributing to the content of these. Although care plans were written in the first person, the patients had not contributed to these. One patient said he had never seen his care plans. Care plans were not in easy read or accessible format.

Patients told us they were aware of the independent mental health advocate (IMHA) and she attended meetings with them. One patient said the advocate was helping him to draft a complaint letter. One patient told us he rang the commissioners or the police if unhappy with his care.

Another patient said he had asked for the phone number for commissioners but had not been given this. Patients were not clear on how to complain. Two patients said they had not had their rights read to them.

We spoke to three carers and received comment cards from five carers. Feedback about the service was variable. Poor communication was a common theme, with particular reference to the phone not being answered and at weekend difficulties in visiting as there was no reception staff on duty. One relative told us they had left without being able to visit their relative as planned as the door and phone had been unanswered whilst they were waiting outside. We had feedback about ward rounds being cancelled without relatives being informed. One patient told us that meetings were scheduled early in the morning and because of travel distances his mother could not attend, they had asked to change meeting times and this had been refused. Several carers gave positive feedback about the skills of staff, the caring nature of the staff they encountered, feeling staff treated their relative with dignity and respect and that their relative was experiencing good care.

Visits generally took place off the ward. These needed to be planned in advance and rooms needed to be booked for visits.

Patients said there was a high turnover of staff and often staff on duty who were not familiar to them. One patient told us GP appointments were cancelled because of staffing shortages. One patient identified difficulties in having one to one time with their key worker as they would get moved to work on other wards. Staff told us they were moved to work on other wards but this was not recorded on the duty rotas we saw.

The hospital told us that they asked patients to participate in an annual survey. The only results available to review were from the 2014 survey. We had asked for the 2015 survey results but these have not been made available.

A patient meeting took place on a monthly basis. Minutes of these captured themes including that patients had raised issues of staff talking in other languages on the wards and staff using mobile phones whilst on duty. Often alternative activities were suggested by patients but there was no clear actions following from this. There were no individual ward meetings.

Inadequate

Wards for people with learning disabilities or autism

There was little evidence of patient involvement in the running of the service. One patient had become involved in a piece of work looking at ward environment and making ward environments more comfortable, for example, new artwork and soft furnishings.

There was no use of advanced decisions in this service.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Inadequate

Access and discharge

At the time of inspection, there were 22 patients resident in the hospital, with total capacity for 28 patients.

The registered manager received the information regarding new referrals. Managers reviewed the referral information and often the general manager and clinical nurse manager would undertake an assessment. There was no clear multidisciplinary assessment. We discussed in detail the admission of two individuals with complex needs to the service in 2015. Managers told us that their initial assessment of the individuals was that they could not meet their needs and were unsuitable for the service. The hospital had admitted both patients as emergency admissions whilst suitable placements were sought. They had now been in the service for six months with very little progress in terms of suitable placements being identified. We observed the environment was not conducive to their needs in terms of space, noise levels, patient mix and staff knowledge and skills. We raised this with managers and senior managers who were escalating this with commissioners and a potential service had been to assess one patient.

Prior to inspection, figures provided by the service suggested there were no delayed discharges. On inspection, it was not evident that the service had a system to identify or monitor delayed discharge. Several patients were noted to be waiting for accommodation or placements to be identified and may have been otherwise ready for discharge. Following inspection, further information provided indicated six patients who were classified as delayed discharge. The information did not show how long their discharge had been delayed.

There was no evidence in care records of discharge planning or pathways/outcomes/steps necessary for discharge. Staff said that identification of a discharge pathway and potential discharge plan was viewed as a role of the care co-ordinator or case manager.

One patient's file contained a moving on file which had a series of tasks to be completed, but no pathway or plan for discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The five wards each had communal areas of a lounge, dining area and small quiet rooms. There were meeting rooms located away from the wards, which the hospital used for multidisciplinary team meetings, patient meetings and family visits.

There was no clinic room available with an examination couch to allow physical examinations. If patients needed to be examined on a bed, the doctor did this in their bedroom.

To access Dali ward, patients had to walk through DaVinci ward bedroom corridors and to access Picasso ward patients had to walk through Monet ward bedroom corridors. This meant that the privacy and dignity of patients was not being maintained at all times.

There was a lift available if needed to the first and second floor wards.

There were no facilities for patients to make private phone calls. Some patients had access to their own mobile phones subject to individual plans but for those patients who did not they were able to use the ward office phones under staff supervision.

All wards had access to outside space. There was a large communal garden area but this was untidy with many discarded cigarette ends at the time of this inspection. Dali ward patients had access to a separate garden area with well-maintained furniture and shelter. One patient on the unit had access to a key card allowing him to go into the garden area unsupervised, other patients required staff to escort them. Patients on Matisse ward were not accessing

fresh air. The space available to them was two floors down, both patients were described by staff as reluctant to use this. Both of the patients had escorted community leave, but only one patient had used leave. In the previous two months this had only been used to attend medical appointments.

Most patients said the food was reasonable, although the advocate said she received regular complaints that the portions were small. One patient described the food as poor and said suggestions were made but not actioned. Another patient felt the food lacked flavour and was bland. The food we observed was attractively presented and portion sizes appeared reasonable.

The advocate completed a food survey in November 2015. Four patients felt portion sizes were too small. Five patients requested more fruit. Five patients reported too many sandwiches. In terms of overall food rating, three felt the food was good, six felt food was OK and three reported the food was not good, with another nine patients who did not express a view.

Some patients were able to cook themselves on the ward and there were freezers and cupboards for storing ingredients. Several patients across the service were able to cook occasional meals for themselves using ward based kitchens. However, this seemed to be limited to patients who already had these skills with no similar time allocated to patients without these skills to begin to acquire them or to cook with staff assistance. One patient mentioned a limited occupational therapy budget for cooking ingredients and supplies.

On all the wards, the kitchen areas were locked and so patients had to ask staff for access to the kitchen. This meant that patients had no access to drinks except when staff let them into the kitchen. Some patients told us they tended to purchase and keep snacks and drinks in their bedrooms but this was dependent on finances and access to leave.

There was evidence of patients being able to personalise their bedrooms and many patients had TVs, stereos, games consoles and DVD players available to use in their rooms.

Some patients had keys to their own rooms on Dali and DaVinci wards, but on Monet ward none of the patients had keys to their own bedrooms.

Lockers were available for patients to store possessions and restricted items and in many kitchens, patients had their own food cupboard.

There was access to activities, including occupational therapy (OT) sessions and education. OT weekly activities included crafts, sports, breakfast group, current affairs group, a “Who am I?” group, baking, swimming and games. Staff and patients referred to the lack of challenge in some of the sessions, for example, art groups that were just colouring in.

Patients had personal planners in their files, although these were not always up to date and sometimes included activities that patients could not attend, for example groups or activities, which required a certain level of authorised leave. All planners were in small font with no easy read symbols or pictures.

There were no planned ward based or nurse led activities. Staff said they would play board games or other diversional activities on the ward but we saw no evidence of this during inspection. There were no activities scheduled at weekends.

One patient was involved in a community based college course. No patients were involved in supported employment schemes. Prior to inspection, we contacted community resources that we were told patients had attended. We received only one response to say they had not had patients attend from the hospital for several years.

A number of patients told us they tended to stay in their rooms and watch television. Staff also reported that some patients spent long periods in their bedrooms.

Support workers facilitated most section 17 leave. Many patients had local leave and would go for a short walk or to the local shops or for a drive in the hospital minibus. There did not seem to be a clear rehabilitation focus to most leave that was planned during this inspection. In terms of staff clearly planning leave, we were told by one patient that he had been on leave that morning to the local supermarket and had got to the checkout to find that he had to put several items back as he did not have enough money. This suggests both individual difficulties in budgeting and staff not assisting or being aware of this during the trip.

Meeting the needs of all people who use the service

Inadequate

Wards for people with learning disabilities or autism

There had been adjustments made for patients and visitors who required disabled access. The main entrance was accessible by ramp, although there was little room within the initial airlock access for a wheelchair.

There had been no consideration given to the environment on Matisse ward in terms of providing an environment which was autism friendly. Both patients were encouraged to stay in a fairly small lounge, for people who usually require space. There was loud music playing and a game of skittles being played by one patient, the other patient who preferred to walk freely and look out of the window was being told to sit down by staff.

The alarms used throughout the wards sounded when there were incidents. The alarms also sounded when doors were left open for longer than ten seconds, which happened frequently during this inspection. The sound of the alarms were was loud and high pitched and sounded frequently throughout the wards. Consideration did not seem to have been given that some patients, particularly those with autism, may find this repeated noise distressing.

Information leaflets and planners were not available in easy read formats. There were no easy read Mental Health Act information leaflets on the wards. On two wards, there were easy read medication leaflets. On one ward, staff said they had access to a computer application to convert information into a pictorial form.

There was no evidence of communication assessments or plans and no individualised approaches to communication. One patient had board maker symbols however they were in his activity box and when explored with staff they said that they used these occasionally with them. In relation to another patient who did not use speech to communicate, staff said they tried picture cards but they did not work whereas the concept is to introduce these gradually but consistently but this had not happened. Staff had received no communication skills training. There is good practice guidance available regarding this, for example, the five good communication standards published by the Royal College of Speech and Language Therapists includes ensuring there is an assessment and description of communication needs, supporting individuals to be involved in their care, using best approach, making users want to communicate in terms of environment and supporting and enabling people to express their needs.

There was not a system in place to show at a glance how best to support patients and what was important to them, for example, one page profiles which would include at a glance the key pieces of information that staff need to know to enable both the patient and staff to work best together.

We saw notice boards on Da Vinci and Monet wards with easy read literature about the hospital, staff roles, complaints and other issues, but on Dali and Picasso wards these boards were blank. On Dali ward, this information was on the side in the ward office. There was no information board on Matisse ward.

Listening to and learning from concerns and complaints

Staff and patients were unaware of the complaints procedure. The advocate was supporting patients to complain but patients were not aware of how to complain directly. One member of staff told us there was a comments box in the lounge which was then noted to be a CQC comments box supplied for this inspection. Staff said they would help patients to write down, give paper for patients to use or direct them to a manager.

There had been no complaints received during January or February 2016. Two complaints received between October and December 2015 were reviewed, these had been made by family members not by patients. These had been completed by managers as per the complaints policy, including meeting with complainants and providing written responses. One of these complaints was noted to be partially upheld, although it appeared all the issues raised had been found to be correct. A comprehensive letter had been sent both apologising for the errors and outlining plans to ensure the problems did not re-occur.

A recent initiative had been started with talk to the manager posters and sheets to request to speak to the registered manager and these were displayed on two of the wards. One patient had used this to raise issues and it was recorded that he had met with the manager and the issues had been resolved.

Are wards for people with learning disabilities or autism well-led?

Inadequate

Wards for people with learning disabilities or autism

Inadequate

Vision and values

The statement of purpose contained aims for the service rather than specific visions or values. Visions and values were displayed on the website.

Staff were not aware of a corporate vision or values, but told us of their own values and reasons for working in the service. Some staff questioned whether the service was operating as a rehabilitation service.

Staff felt they received good support from the hospital management team and felt they were approachable and responsive. Patients said it was difficult to speak to any of the managers if they wanted to speak to them, as they were always busy.

Good governance

There were serious concerns about the governance arrangements within this service. This related to overall administration and oversight of the Mental Health Act, oversight in relation to medicines management, staffing levels and the training provided to staff.

When concerns had been identified which could have affected service delivery, for example the administration of the Mental Health Act, these had not been reported to the company management and the board by the registered manager. Although there was a framework for information to be communicated from the hospital to the board this did not appear to have been effective in allowing good oversight of issues in the hospital.

Many of the issues identified during the inspection were placed on a local risk register in October 2014. All of these items had been closed by the registered manager and were assessed as low risk. However we found evidence that this was not the case.

There was a comprehensive audit programme in place but this had not proved effective in identifying areas of concern in relation to the Mental Health Act or medicines management.

There were clear deficits in knowledge in terms of good practice guidance across the management team and the dissemination of this to clinical staff. This included relevant National Institute for Health and Care Excellence guidance, Department of Health guidance on reducing restrictive interventions and the updated Mental Health Act code of practice.

This was also clear in reviewing organisational policies, which did not reflect up to date guidance. For example, Mental Health Act policies had not been reviewed when the updated Mental Health Act code of practice had come into operation in October 2015. The positive handling policy was updated in February 2015 but does not reference the Department of Health guidance on reducing restrictive interventions, published in 2014 or the NICE guidance titled Violence and aggression: short-term management in mental health, health and community settings, published in 2015. It was overdue for review which had been listed for February 2016.

There was no duty of candour policy at the time of inspection.

Leadership, morale and staff engagement

Staff spoke of feeling supported by the management team and being able to approach managers. However, in a staff survey in 2015 whilst 61% of staff felt supported by the general manager the figures were lower for both the registered manager and clinical nurse manager. Over a third of staff (35%) reported feeling unsupported by the clinical nurse manager with 17% reporting being unsure. The clinical nurse manager's main roles were around supporting staff.

We reviewed four recruitment files, one file of a staff member being managed under the sickness policy and a selection of exit interviews conducted following resignation. The reviews showed that the appropriate policy was followed and issues were dealt with promptly.

Prior to the inspection, the provider had identified no concerns which needed to be reported to any professional bodies with regards to staff conduct. There were no grievances being pursued, no disciplinary proceedings, no performance management monitoring and there were no allegations of bullying or harassment.

The staff survey in 2015 asked about teamwork. For an item relating to working well as a team, 35% agreed with this item, whilst 48% were not sure and 17% of staff disagreed. Only 17% of staff felt the performance of the team had improved in the previous six months. In terms of

relationships with managers 39% of staff felt their line manager listened to the views and opinions of others, but 43% disagreed. The action plan following on from this was to ensure regular staff meetings were taking place, to ensure regular supervision was taking place, to introduce the talk to the manager initiative, to look at a team building day and set up an additional monthly forum for staff. There had not been a team building day or additional support forum arranged.

There were no opportunities for leadership or development and we were told staff often left for promotion or better prospects. Staff did not describe any opportunities to feedback around the service or opportunities to be involved in developments or service improvements.

Commitment to quality improvement and innovation

Bigfoot had commissioner monitoring visits in December 2015 which resulted in a service improvement plan being put in place by the lead commissioner because there were concerns about documentation, training levels, staffing, supervision, meetings, service user finance, Mental Health Act administration and psychology provision. There was a follow up monitoring visit, which took place in February 2016 which identified improvements in many areas. However, at this inspection, we found that some issues had not been addressed effectively which had been completed as part of this plan. For example, not all clinical rooms had sharps bins, which had been rectified following the December visit but had become an issue again at this inspection. There were still issues with duplicated and missing documentation in case files. Adherence to managers hearings guidance was due for completion prior to this visit but was still not occurring.

Bigfoot did not participate in any national accreditation schemes such as Accreditation for Inpatient Mental Health Services (AIMS) or the Quality Network for Inpatient Learning Disability Services (QNLD).

Fit and Proper persons test

The Fit and Proper Person Requirement (FPPR) is a regulation that applied to all independent health providers from April 2015. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role.

Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check (DBS) and a full employment history).

The provider had a Fit and Proper Person Test policy to meet the Fit and Proper Persons requirements. The measures and declaration were implemented in May 2015. The policy established a process to monitor the provider was meeting its duty. We reviewed the files of three executive and non-executive directors and all contained the required information. There was a system in place to ensure that this was reviewed annually.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must put plans in place to ensure staff are aware of ligature points within ward environments and mitigation plans for these.
- The provider must undertake work to en-suite bathrooms which are not fit for purpose and pose a hazard to patients.
- The provider must review staffing levels and skill mix including qualified nurse ratios as there was often one qualified nurse for two wards.
- The provider must monitor planned leave and occasions where this is cancelled.
- The provider must ensure that the observation policy is followed.
- The provider must ensure there are positive behavioural support plans for those patients that present behaviours that may challenge.
- The provider must review the medication policy to ensure staff have guidance in relation to high dose antipsychotic treatment and rapid tranquillisation.
- The provider must ensure sharps bins and medicines disposal bins are available on each ward.
- The provider must ensure that medicines fridge temperatures are checked daily and that staff know how to report any problems.
- The provider must ensure that all staff are aware of the Duty of Candour and produce guidelines to support staff in implementing this.
- The provider must ensure that risk assessments are completed and kept up to date.
- The provider must ensure that necessary background and historical information regarding patients is obtained when needed.
- The provider must ensure that copies of GP records and investigations and results are available within the hospital records.
- The provider must ensure that care plans are recovery focussed and patient centred, with clear outcomes identified.
- The provider must devise a care plan for the patient at risk of choking using the assessment completed by the speech and language therapist and ensure staff follow this.
- The provider must review the current level of psychology input
- The provider must provide autism awareness training and communication skills training for staff.
- The provider must review the administration and oversight of the Mental Health Act and deprivation of liberty safeguards.
- The provider must review the procedure for arranging managers hearings at the point of section renewal.
- The provider must review all Mental Health Act policies and revise in line with the Mental Health Code of Practice 2015.
- The provider must ensure that all patients affected by serious errors identified during this inspection are informed and the incidents investigated.
- The provider must ensure that written information Is available in easy read and pictorial formats on all wards, including Mental Health Act leaflets, ward based and individual planners and medication information.
- The provider must review all patients against delayed discharge criteria to clearly identify these.
- The provider must devise a means to allow patients to make private phone calls.
- The provider must consider the difficulties presented in access to Dali and Picasso wards of walking through another ward.
- The provider must ensure staff and patients are aware of the procedure for complaints.
- The provider must review the governance arrangements in terms of information assurance.
- The provider must review the audit arrangements particularly in relation to the issues identified in this inspection.

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

Outstanding practice and areas for improvement

- The provider should consider the noise hazard presented by frequent alarms sounding for patients who are hypersensitive to noise.
- The provider should review the use of blanket restrictions, for example, accessing kitchen areas.
- The provider should review how incidents are analysed and lessons learnt are disseminated to staff.
- The provider should consider ways to disseminate best practice guidance effectively within the service.
- The provider should consider the use of outcome measures appropriate to learning disability services.
- The provider should consider ways to meaningfully involve patients in the running of the service.
- The provider should encourage regular ward based meetings for patients.
- The provider should consider the use of a one page profile or summary of an individual's needs, preferences and communication needs.
- The provider should consider development opportunities for staff working in the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Person centred care** **How the regulation was not being met:** Assessments were not carried out collaboratively with patients. Care plans were not person centred or recovery focussed. Written information was not available in easy read and pictorial formats, including Mental Health Act leaflets, ward based and individual planners and medication information. This was a breach of regulation 9 (3) (a) (b) (c) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment** **How the regulation was not being met:** Patients and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. This included unidentified ligature points, tiles coming away from bathroom walls and flooring which presented a trip hazard.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 15 (1) (e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Duty of Candour** **How the regulation was not being met:** Patients and their relatives were not informed of errors when these were identified. There was no duty of candour policy at the time of inspection. This was a breach of regulation 20 (1) (2)

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 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider was failing to treat service users with dignity and respect, failing to ensure the privacy of service users and was not supporting the autonomy, independence and involvement in the community of the service user.** **Therefore the provider was** **failing to comply with regulation 10 (1) and (2) a and b. This was because:** • We saw communication that was not respectful during an observation period on Matisse Ward. • We observed staff ignoring people's preferences on Matisse Ward. • There was a lack of understanding by staff of communication methods and means of communication. • Staff did not knock on bedroom doors before entering • Most patients had no access to a phone to make private phone calls. • To access Dali ward, patients had to walk through DaVinci ward bedroom corridors and to access Picasso ward patients had to walk through Monet ward bedroom corridors. This meant that the privacy and dignity of patients was not being maintained at all times. **We served a warning notice to be met by 3 June 2016.**

This section is primarily information for the provider

Enforcement actions

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

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

The provider was failing to ensure that staff followed policies and procedures about managing medicines, including those related to infection control.

These policies and procedures should be in line with current legislation and guidance

and address:

o Supply and ordering.

o Storage, dispensing and preparation.

o Administration.

o Disposal.

o Recording.

Therefore the provider was

failing to comply with regulation 12 (2) g. This was because:

- Sharps bins and medicines disposal bins were not in place in all clinics.
- There were two faulty fridges which contained medicines
- Out of date medicines were being dispensed.
- A higher dose of as needed medication than was prescribed was given to a patient on three occasions.
- One patient had been administered medication intramuscularly when this was prescribed orally.
- Five patients were prescribed medication above maximum BNF limits with no identification of this or increased monitoring.

This section is primarily information for the provider

Enforcement actions

- One patient was administered medication not authorised by his T2 consent to treatment form.
- Medicines were not ordered in a timely fashion.
- A prescribing error in relation to antibiotics was found.

We served a warning notice to be met by 3 June 2016.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have systems or processes established and operated effectively to

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Therefore the provider was failing to comply with Regulation 17(2)(a)&(b)&(c)

This was because

- Systems were not in place to adequately monitor the safety and quality of the service.

This section is primarily information for the provider

Enforcement actions

- Information which seriously affected the service, for example the administration of the Mental Health Act, whereby four patients had periods were their legal detention had lapsed, had not been reported to the company management and the board by the registered manager.

- There was no policy or procedure outlining the Duty of Candour. We found other examples where mistakes had been made and patients had not been apologised to, for example, a patient who had been given intramuscular medication without a valid prescription for this.

- There was a comprehensive audit programme in place but this had not proved effective in identifying areas of concern in relation to the Mental Health Act or medicines

  management.

- A process for monitoring organisational policies and ensuring these were reviewed by

  people with appropriate skills and competence was not in place.

- We became aware of incidents during inspection relating to the administration of legal safeguards and medication which had not been reported as safeguarding incidents to the local authority.

- There was a lack of oversight afforded to Matisse ward in terms of staffing, management, care plans and risk assessment.

- Care plans showed no evidence of patient involvement and were not recovery focussed.

This section is primarily information for the provider

Enforcement actions

- Risk assessments were incomplete.
- There were no personal behaviour support plans in use.
- Care records were held as paper files. The GP records were held elsewhere and not accessible to the hospital staff. Psychology records were also held separately and did not form part of the main clinical record. We did not see psychology notes or reports in the clinical records reviewed.

We served a warning notice to be met by 26 August 2016.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 18 Staffing** **The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced** **persons.** **Therefore the provider was failing to comply with Regulation 18: Staffing (1). This was because:** • Staff did not receive training in autism awareness, communication skills or person centred planning.

This section is primarily information for the provider

Enforcement actions

- There were not sufficient numbers of qualified nurses available throughout the service on day and night shifts.
- Matisse ward was staffed by support workers for the majority of the time.
- There was a lack of qualified nurse leadership and ownership in relation to Matisse ward, with patients having infrequent keyworker sessions, medication not being ordered and care plans and risk assessments not up to date.

We served a warning notice to be met by 3 June 2016.