Bloomfield Court and 5,6 Ivy Mews

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. We will 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 Bloomfield Court and 5, 6 Ivy Mews as inadequate because:

- There were a high number of incidents of violence in the service that staff did not always report. There were also a high number of patient restraints. Fewer than half of the staff had undertaken training in approved restraint techniques.
- There were not enough qualified nurses on duty in the service. The provider had not filled a significant number of bank and agency shifts. Forty percent of staff had left the service in the previous year.
- Most care plans were not specific or detailed, and did not meet all of the patients' needs. Patients were not involved in the development of their care plans. Staff did not support patients appropriately to make decisions about their care or treatment.
- There were low completion rates of staff training. Staff did not have the skills needed to meet patients' needs.
- The wards, and Ivy Mews, were not clean or well maintained and appeared institutional. The environment did not promote comfort and recovery.
- There were no ligature-free fixtures in some patients toilets and bathrooms. The entrance gate and doors to the service were not secure.
- Some staff did not know how to respond if they observed or heard about poor care, neglect or abuse. Referrals to the local safeguarding team were delayed by staff.
- One patient had been deprived of their liberty without lawful authority for almost 18 months. Another patient's care constituted long-term segregation. This patient did not have multidisciplinary reviews in accordance with the Mental Health Act Code of Practice.
- Two patients had been in the service for four years. There was little progress in their care and treatment and no clear discharge plans.
- The systems and processes in the service were not effective. They did not effectively assess, monitor and improve the safety and quality of the service.
- The service had five managers or acting managers in the three years before the inspection. There was a lack of clinical and non-clinical leadership in the service.
- The management team were out of touch with day-to-day events in the service. There was little understanding of the extent of the improvements needed.
- We informed the provider of our serious concerns regarding the safe care and treatment of patients - Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider voluntarily made a commitment to stop all admissions of patients to the service immediately until all areas of non-compliance had been resolved. The provider also produced an action plan. The Care Quality Commission will monitor the progress of the action plan closely.
- We identified concerns regarding other areas of the service. We have taken action regarding these concerns.

Summary of findings

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Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to Bloomfield Court and 5,6 Ivy Mews

Bloomfield Court and 5, 6 Ivy Mews are registered to provide care and treatment for people with learning disabilities, autism and mental health problems. At the time of the inspection, there were 15 patients at the hospital. Ten patients were detained under the Mental Health Act and four were subject to Deprivation of Liberty Safeguards (DoLS).

The service consists of:

Bloomfield Court - ward for six male patients

Jasmine Court – ward for six female patients

Ivy Mews – six two-storey apartments.

All the buildings are inside a secure perimeter.

Bloomfield Court and 5, 6 Ivy Mews are registered to provide:

Accommodation for persons who require nursing or personal care; assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures, and treatment of disease, disorder or injury.

There had been no registered manager for the service for 17 months.

The service received referrals from statutory services inside and outside of London.

Bloomfield Court and 5, 6 Ivy Mews has been inspected four times since 2010. Inspections took place in March 2013, June 2013, January 2014 and November 2014. Following the inspection in November 2014, we issued two compliance actions. These related to fire safety, and staff training and supervision. On this inspection, the service was compliant regarding fire safety and staff supervision. There were continuing concerns regarding staff training.

Our inspection team

Team Leader: Steve George, Care Quality Commission

The team that inspected the service comprised a CQC inspector, a CQC inspection manager, a mental health act reviewer, a CQC medicines manager, a CQC pharmacist specialist and three specialist advisors; these were a consultant psychiatrist in learning disabilities and two senior learning disability nurses. The inspection was also supported by an expert by experience. This is someone who has used, or cared for someone using, similar services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. The start date for this scheduled inspection had been brought forward due to concerns regarding the health and safety of patients.

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?

Summary of this inspection

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

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

During the inspection visit, the inspection team:

- visited all parts of the service and looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 10 patients who were using the service;
- spoke with three relatives or carers of patients using the service;
- spoke with the director of operations, area operations manager and acting manager for the service;
- spoke with 10 other staff members; including a doctor, nurses, speech and language therapist, assistant psychologist, speech and language therapy assistant, rehabilitation facilitators and team leaders;
- collected feedback from seven patients using comment cards;
- looked at 10 care and treatment records of patients;
- carried out a specific check of the medication management in the service, 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

Almost all of the female patients were positive about the service. They liked the staff and enjoyed the activities. They were also positive about their leave. Their views of the food were mixed. One female patient was less positive. They wanted to move on from the service and felt the staff bullied them. They did not enjoy the activities available and did not feel safe.

The male patients were less positive. They wanted to leave the hospital but were unable to say why. One patient said they did not feel safe there.

Before the inspection, a comment box had been placed in the service. We received seven comment cards from patients. All of the comment cards were positive and praised staff.

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:

- In the previous six months, there were 139 physical assaults in the service. Staff did not report all incidents. Staff appeared to accept a high level of violence.
- There were 101 incidents of restraint in the six months before the inspection. Fewer than half of the staff (48%) had undertaken restraint training. Staff rarely recorded the position patients were restrained in.
- Forty-two per cent of bank and agency shifts were not filled. The staff turnover rate in the previous 12 months was 40%.
- There were not enough qualified nurses on duty. The number of nurses did not ensure that safe and high-quality care was maintained.
- There were no ligature-free fixtures in some patients toilets or bathrooms. These risks were not sufficiently reduced. The entrance gate and doors to the service were not secure.
- Patients were regularly 'redirected' to their bedrooms. There was a risk that 'redirected' patients were being placed in de facto seclusion.
- The kitchen refrigerator recorded a temperature of 17 degrees. This meant that food was stored at too high a temperature and was not safe to be eaten.
- The service was not clean or well maintained.
- The average mandatory training rate for staff was 67% in the previous year.
- There was no evidence that staff had attempted to apologise to patients when potentially serious mistakes were made.

However:

- When the service was short staffed, staff prioritised escorting patients on leave.
- Medicines management in the service was good.

Are services effective?

Inadequate

We rated effective as inadequate because:

- There was a lack of overall day-to-day clinical leadership in the service. The lack of a clinical psychologist affected the multidisciplinary team's (MDT) ability to meet patients' needs.

Summary of this inspection

- Most care plans were not specific or detailed. Patients with sleeping difficulties and those with autism did not have their specific needs addressed.
- Psychological, communication and daily activity assessments were carried out by unqualified staff. Qualified staff did not supervise or countersign these assessments.
- One patient had been deprived of their liberty without lawful authorisation for more than one year. Most staff had little understanding of the MCA and had not received MCA training. Patients were not supported to make their own decisions.
- One patient's care constituted long-term segregation. Reviews of long-term segregation were not carried out in accordance with the MHA code of practice.
- Patients did not have an annual physical health check. Patients' physical health was not always monitored appropriately.
- MDT meetings were not frequent enough to review and monitor the care of patients.The effectiveness of MDT meetings was limited by some MDT members not attending.
- Rates of staff training were low. Fewer than 20% of staff had training in suicide prevention, communication skills, and supporting patients to develop skills. Just over a quarter of staff (27%) were trained in aspergers and autism.
- More than 20 documents were in the wrong patient's care and treatment record. Some documents did not have patients' names recorded and were not signed. Some had blank spaces where important information should be.

However:

- Antipsychotic medicine was not routinely used. This was in accordance with national guidance.
- All patients had a functional analysis of their behaviour. This was in accordance with NICE guidance.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Most patients did not contribute to their care plans. Care plans simply stated that the patient had not contributed or could not communicate.
- On some occasions staff members' approach was not appropriate. One patient was told 'sit down or go to your bedroom'. Some progress notes in clinical records referred to patients 'playing up'.
- A closed circuit television camera pointed directly into the bedroom of a female patient. Virtually none of the patients had curtains or blinds in their bedroom.

Summary of this inspection

- The patients' community meeting had not been held regularly. When it was held, there was no record that action was taken as a result of patients' views. Patients raised some of the same issues at every community meeting.

However:

- Staff listened to patients and responded to their needs. Some staff spoke enthusiastically about patients and displayed warmth and understanding.
- Overall, patients were positive regarding the staff. They felt helped and supported by staff.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

- Bloomfield Court and Jasmine Court appeared institutional. The walls were bare with no pictures or shelves. The environment was not well looked after and did not promote comfort.
- Two patients had been in the service for four years. There was little progress in their care and treatment and no clear discharge plans.
- There was no information displayed regarding complaints, helplines, mental health problems or treatment.
- The patients' menu consisted of meals high in calories and carbohydrates. There was limited fresh fruit and vegetables. A number of patients had significant weight gain since being admitted to the service.
- Complaints were not a standing agenda item at the team meeting. The service did not monitor formal complaints or informal concerns to identify themes and trends.

However:

- Staff were aware that formal complaints should be directed to the manager.
- Patients were able to personalise their bedrooms.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The systems and processes in the service were not effective. They did not effectively assess, monitor and improve the safety and quality of the service. Risks were not appropriately identified, monitored and reduced.

Summary of this inspection

- The service had five managers or acting managers in the three years before the inspection. At the time of the inspection, there had been no registered manager for almost eighteen months.
- The purpose of the service was different according to different managers. Confusion regarding the identity and the role of the service affected patient care and patient safety.
- The information from key performance indicators was limited because of a lack of detail.
- Some staff did not know how to respond if they observed or heard about poor care, neglect or abuse. This meant patients were not fully protected from harm.
- The management team was out of touch with day-to-day events in the service. There was little understanding of the extent of the improvements required in the service. Issues with team building, communication and standards of care were not effectively addressed.
- The acting manager had a defensive, directive, top-down style of leadership. The management team did not have the knowledge, skills or capability to manage the service safely and effectively.

However:

- The new senior management team clearly understood the challenges at the service. They responded quickly and appropriately to concerns that we raised.

Detailed findings from this inspection

Mental Health Act responsibilities

Mental Health Act (MHA) documentation was in good order and stored appropriately. Patients had their rights explained to them on admission and at regular intervals. Information about patients' rights was in an 'easy read' format. Patients had access to an independent mental health advocate.

The service did not recognise that the care being provided to one patient constituted long-term segregation. Medical and nursing reviews were not carried out in accordance with the MHA code of practice.

Two patients had recently passed their initial three months of detention under the MHA. One of the patients had subsequently been administered medicine without a consent (T2) or authorisation (T3) certificate. This had continued for 19 days. Another patient was receiving emergency treatment under Section 62. The provider had not requested a second opinion appointed doctor in good time. Other patients had consent (T2) or authorisation (T3) certificates. Copies of these were attached to their medicine administration records.

MHA training was not mandatory. Ten staff (19%) had received training. However, six of these staff had only received training regarding Section 58 MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a very limited understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS).They could not describe the five principles or the capacity test. MCA training was mandatory and 19% of staff had attended the training.

Four DoLS applications had been made in the previous six months. One was rejected as the patient was already detained under the MHA. The provider had not followed up a DoLS application for a patient for over one year. The patient had not been subject to a DoLS assessment during this time. The patient was subject to significant restrictions and had been deprived of their liberty without lawful authorisation.

Capacity assessments were well documented. However, there was little evidence to show if patients had been supported to make their own decisions. Patients were not supported by an independent mental capacity advocate when important decisions were made.

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

- The front entrance to the service consisted of a high brick wall. The entrance for people was through a gate with metal bars. The gate did not close properly and had to be pulled hard to ensure it was closed. The gate was repaired shortly after the inspection.
- The entrance to Bloomfield Court and Jasmine Court was through two sets of doors. The practice was for one door to be opened at a time creating an 'air lock'. On several occasions during the inspection, the outer door was left open. There was no door closing mechanism fitted to the door to ensure that it was closed.
- The layout of Bloomfield Court and Jasmine Court did not always allow staff to maintain clear sight lines. Although the lounge areas were open spaces, there were no clear sight lines into corridors. The corridors contained mixed use rooms and some patient bedrooms. However, convex mirrors were used in most areas so that staff could see into 'blind spots'. Most patient bedrooms were located on the first floor. The stairways to the first floor, and the first floor corridor were narrow. This was a safety risk in the event that a patient required restraint. Closed circuit television (CCTV) was used extensively throughout the service. This was the case both inside and outside of the buildings. However, there were no signs in the wards informing patients that CCTV was being used.
- Patients' toilets and bathrooms had a number of ligature anchor points. There were no ligature-free fixtures in some bathrooms. Many patients were unsupervised in these rooms. These risks were not sufficiently mitigated. There were also ligature risks in the male garden. These were not within view of the CCTV cameras and did not appear on the ligature risk assessment.
- The service adhered to national same-sex accommodation guidelines. All of the patients in Ivy Mews were male. Bloomfield Court (male) and Jasmine Court (female) had their own separate gardens. However, immediately prior to the inspection a male patient gained access to the female garden. This led to an incident. Immediately after the inspection, the male patient was involved in a similar incident with another female patient.
- The clinic room was very small and there was no examination couch. Resuscitation equipment included an automated external defibrillator (AED), used to restart a person's heart. This equipment, an oxygen cylinder and other equipment were checked daily. All of the equipment was well maintained. Ligature cutters were also available in the clinic room and in four other areas across the service. First aid boxes were available in the clinic room and kitchen.
- The service did not have a seclusion room.
- The service was not clean or well maintained. There were stains on walls, cobwebs and dirty mirrors. Surfaces around sinks, baths and toilets required replacement. There was worn and torn carpet on the stairs. In Ivy Mews, the kitchen worktop areas were dirty and some were damaged. The standard of décor was

poor and some paintwork required attention. Patients cleaned their bedrooms with support from staff. A patient in Ivy Mews refused to allow staff to support them. The patient's flat was very dirty and was an infection control risk. There was a large fish tank in the middle of the Bloomfield Court lounge. It contained dead fish.

- The service undertook infection control audits every eight weeks. A week before the inspection the audit recorded that the kitchen was 100% compliant with infection control. During the inspection, the kitchen refrigerator recorded a temperature of 17 degrees. The cook's daily checks included recording the temperature. During the week, this was recorded as 'yes'. At the weekend, the actual temperature was recorded. In the previous three weeks, the temperature had been recorded up to nine degrees. No action had been taken. We were told that the problems with the refrigerator had been known for some weeks. There was a high risk of food poisoning as food was not stored at the correct temperature. The provider took immediate action when we informed them of this issue. In the clinic room was a sharps bin, used for disposing of needles and sharp objects. The sharps bin had a sticker indicating it had been opened over one year ago. This was an infection control risk. National guidance states sharps bins should be closed and disposed of after three months (Safe management of healthcare waste, Department of Health [DH], 2013).
- There was a cleaning schedule for the service. Not all areas on the cleaning schedule had each box ticked each day. This meant that some areas were not cleaned. Nursing staff working the night shift also had some cleaning tasks to complete.
- The provider had undertaken a detailed environmental risk assessment.
- An annual health and safety audit was undertaken by an external company. A new audit was due at the time of inspection. A health and safety audit checklist was also undertaken. This had taken place every month. However, it had not been undertaken for five months prior to the inspection.
- There were wall alarms throughout the buildings, including in patient bedrooms. Staff carried personal alarms. However, on Jasmine Court a new covered outside area had been built. This was used as a laundry area. There was no sensor in place for the personal alarms. This meant staff personal alarms would not work in this area. Staff also carried two-way radios.
- The fire alarm and emergency lighting were tested weekly. There was also a monthly fire drill. The fire alarm was maintained on a regular basis. The service had a fire risk assessment undertaken four months before the inspection. However, in Jasmine Court some building work was undertaken several months previously. The green fire exit sign above one door led to a locked storeroom. The new fire exit also had a green sign. The fire assembly point in the female garden did not have a green sign.
- Staff had all of the required pre-employment checks carried out. This included obtaining two references. A satisfactory disclosure and barring service (criminal record) check was also obtained.

Safe staffing

- The staffing establishment for the service was six nurses and 32 unqualified staff of various grades. There were two nurse vacancies in the service. The acting manager and deputy manager were also nurses. The staff sickness rate in the last 12 months was 2%. The staff turnover rate in the last 12 months was 40%.
- There were not enough qualified nurses on duty. The number and grade of staff required had not been subject to a formal needs-based assessment. Nursing staff worked a day shift or a night shift. During the day, two nurses were on duty. At night one nurse was on duty. There were three main patient areas, and all of the patients had complex needs. The number of nurses did not ensure that safe and high quality care was delivered. Nurses were supported on each shift by rehabilitation facilitators. There were also senior rehabilitation facilitators and team leaders. There were nine of these staff per day shift and six staff at night. However, during the inspection there were 13 of these staff during the day and 10 staff at night. These additional staff provided continuous one-to-one support for two patients. One patient required the continuous support of two staff.
- Bank and agency nursing staff were used in the service. They covered staff vacancies, sickness and absence. They were also required for other activities such as additional observations. Three months prior to the

inspection, of 204 shifts which needed filling, 117 shifts were filled. This meant that 87 (42%) of shifts were not filled. There was a shortage of staff on two to four shifts each week. During the inspection, two night shifts were short of two staff. Recently the service had used agency nurses to fill shifts at night. The provider attempted to use the same three agency nurses. The nurses arrived early for their first shift to have an induction. The agency staff induction form contained 23 items to be covered. We were told that a nurse on the day shift would stay late. This was to complete the induction with the agency nurse and to administer night time medicines.

- Permanent staff often worked additional bank shifts. Some staff were working excessive hours. During the two weeks before the inspection, staff worked over 60 hours a week on nine occasions. One member of staff did not have a day off in the week and worked more than 80 hours. Staff had a 45-minute break during their 11 hour or 13.5 hour shifts.
- The acting manager was able to adjust staffing levels to meet the needs of patients. However, they were unable to do so without involving a more senior manager.
- A nurse was rarely visible in any of the communal areas of the service. Nurses spent the majority of their time on administrative tasks. Work was not organised so that nurses could spend most of their time with patients. This affected safety and the quality of care. We could find no records of patients having one-to-one meetings with their named nurse recently.
- Patient activities and escorted leave were rarely cancelled. When the service was short staffed, staff prioritised escorting patients on leave.
- There were always enough staff in the service to restrain a patient, if required.
- The level of consultant psychiatrist input was very limited in the service. Three consultant psychiatrists each worked one day every four weeks. Professional guidance indicates that a full-time consultant psychiatrist would be needed for the service (Safe patients and high-quality services: a guide to job descriptions and job plans for consultant psychiatrists, Royal College of Psychiatrists, 2012). There were no other doctors in the service. The level of medical input did not ensure that patients were re-assessed, monitored and reviewed appropriately. However, there was an on-call medical rota. The consultants attended the service at other times when staff requested. This was often to admit a new patient.
- The average mandatory training rate for staff was 67% in the previous year. Staff were required to undertake 11 types of mandatory training. Less than half of the staff (48%) had undertaken training in preventing and managing aggression and violence. This included restraint training. The same percentage of staff had undertaken nutrition and hydration training. Health and safety training had been undertaken by 73% of staff. There was a risk that staff did not have the necessary knowledge and skills to provide safe care. The cook had not undertaken level 2 food hygiene training. The cleaner had not had infection control training. There was a risk that these staff did not have the knowledge to prevent the spread of infection. The low rates of staff training had been discussed some months previously in the manager's and team meetings. In the staff office were two folders labelled 'workforce development plan' and 'training schedule for service.' Both folders were empty.

Assessing and managing risk to patients and staff

- The provider reported that there were no incidents of seclusion in the previous six months. However, patients were regularly 'redirected' to their bedrooms. On some occasions, this was as a result of an incident or a patient's behaviour. On other occasions, the reason was unclear. All grades of staff could 'redirect' a patient to their bedroom. The reason and length of time the patient was in their bedroom was not always recorded. Whether the patient agreed to go, or stay in, their bedroom was not always recorded. There was a risk that 'redirected' patients were being placed in de facto seclusion. None of the patients subject to DoLS authorisations had such a restriction contained in the authorisation. The informal patient in the service would also be very restricted in their movement in some circumstances. Their clinical record described the circumstances and stated that it would not be seclusion. The provider's seclusion policy was due to be updated and did not include guidance from the current MHA code of practice. The provider also had a form entitled 'record of bedroom nursing.' The wording of this form

potentially created confusion that 'bedroom nursing' was different from seclusion. The design of the 'record of bedroom nursing' form did not ensure that the MHA code of practice guidance would be followed.

- There were 101 incidents of restraint in the six months prior to the inspection. Between two and six patients were restrained each month. Forty-nine restraints involved one patient over a period of two months. Some incident forms recorded that de-escalation had been attempted before restraint. During the inspection, we observed staff use de-escalation techniques during one incident. Staff responded professionally and prevented the situation becoming more serious.
- The provider reported no episodes of prone restraint within the previous six months. However, almost all incident forms were incorrectly completed. The position of the patient, restraint holds and length of time of restraint were not recorded. Body maps of the patient were not recorded when they should have been. Where medicine was administered the name, dose and route were not recorded.
- One patient was subject to long-term segregation. This meant they had very limited, if any, contact with other patients. The patient was supported by two staff continuously.
- There was no restrictive intervention reduction programme as required by national guidance (Positive and proactive care: reducing the need for restrictive interventions, DH, 2014). However, the provider published their strategy for this work during the inspection.
- Patients had a risk assessment on admission to the service. However, information on patients' past risk incidents was not always available. When this information was available, it was not always included in the patients' risk assessment. For example, one patient had made two suicide attempts in the past few years. Another patient was at risk of choking on food. These were not recorded in their risk assessments. As patients had multiple areas of risk, a separate risk assessment was undertaken for each area of risk. No patients had a risk assessment identifying the potential risk of institutionalisation. Five patients had a risk assessment for dysphagia (choking). Two of these risk assessments indicated the patients were at high risk. None of these risk assessments contained the patients name anywhere on the form. A number of patients' documents were found in other patients' clinical records. If the dysphagia risk assessments were moved to another patients' record there would be no way of knowing. One patient had a dysphagia risk assessment which indicated a moderate risk of choking. A patient care plan, developed the same day, stated that the patient no longer had difficulties with eating and drinking. All of the dysphagia risk assessments had dates for the assessment to be reviewed. There was no record that any of them had been. Some other risk assessments did not contain the patient's name. However, on reading the detail of the risk assessment, the patients name was recorded. Risk assessments were not always updated after incidents.
- Positive behavioural support (PBS) plans were developed for each patient to assist with risk management. This was best practice (DH, 2014). The PBS plans identified the triggers to, and ways to manage, particular risk behaviours. Some patients' risk management plans had large sections of the PBS plan copied into the risk assessment. This made the risk management plan long and was of limited use. Staff were unlikely to be able to remember all of the details of the plan. Other risk management plans did not contain enough detail. Strategies to manage patient risks, identified in the PBS plan, did not appear in the risk management plan. Where the patients' risk was of violence, some risk management plans did not contain enough primary or secondary strategies. These are methods to prevent violence such as distraction or conversation. Some risk management plans focussed more on tertiary strategies, such as restraint. Two patients had very good risk assessment and management plans. Both of these had been written after significant incidents. The plans were detailed and comprehensive. The risk management plans also contained contingency actions. These were actions to take if the management plan had failed. Patient PBS plans were updated monthly. However, the updated information was not always transferred to an updated risk assessment and management plan. A patient in Ivy Mews had adaptations to their flat to manage serious risks. The adaptations were crude and institutional. During the inspection, we found metal screws on the

floor. These were from the adaptations. Having informed staff, we found further screws on another day. The patients' clinical records indicated how risks could be managed without such adaptations.

- The provider had a policy for the therapeutic management of aggression. This referred to some 'best practice' documents. These were published in 1991 and 1999. There was no reference to best practice guidance published in the previous three years. This meant the providers' policy did not reflect current best practice in managing aggression.
- The provider had a policy on searching patients which was due to be updated. However, the provider had an updated policy on the observation of patients. Two patients in the service were continuously observed and supported by a staff member. The patients would be observed for six or seven hours at a time. This practice increased risk. A staff member would be unable to maintain the level of concentration required for such a period. Staff did not maintain an ongoing record of their observations. Instead, they wrote a summary which could cover several hours. Patterns in the patients' behaviour could be missed. This was not in accordance with the providers' policy. One patient required observation and support from two staff. Staff observed this patient for two hours at a time. This was in accordance with the providers' policy. The providers' policy said that patients' observation levels should be reviewed daily. We found patients' observation levels were only reviewed at their monthly ward round. This meant some patients could remain subject to a level of observation that they did not require. One patient was subject to staff observation every 15 minutes during the day. This meant a member of staff would check on the patients' whereabouts. At night, the level of observation was changed to every 30 minutes. However, the patients' risk assessment stated that night time was a period of increased risk for the patient. This meant staff observed the patient less at the time when risks were higher.
- Half of the permanent and bank staff were trained in approved restraint techniques. This meant a significant proportion of staff were unable to maintain their own and others safety appropriately. The majority of incident forms did not describe how patients were restrained. There were some concerns regarding restraint practice. Some staff members described restraint situations which were not in accordance with national guidance (Violence and Aggression: Short-term management in mental health, health and community settings, National Institute of Health and Care Excellence [NICE], 2015a). Without appropriate recording of restraint incidents, it was not possible to understand the extent of concerns.
- There was very limited use of rapid tranquilisation. When rapid tranquilisation was used this was in accordance with national guidance (NICE, 2015a).
- Sixty five percent of staff had undertaken safeguarding adults training. Safeguarding children training was not undertaken by staff. In the previous year, there had been 48 referrals to the local authority safeguarding adults team. During the inspection, two patients made allegations concerning staff abusing them. A senior staff member became aware of one of the allegations. They took no action for two days. When the operations manager was informed, they immediately took action. The other allegation was immediately responded to. The police were informed and the staff member was prevented from working pending investigation. However, a referral to the local safeguarding team was not made for five days.
- Medicines management in the service was good. Medicines were supplied, stored, prescribed and administered safely. The storage and management of controlled drugs was safe. Medicine administration records were completed properly. Medicine prescribed 'as required' (PRN) was individual to each patient. There was very little use of 'rapid tranquilisation'. This is medicine that is administered urgently to reduce patients' level of agitation. There was a low level of pharmacy input into the service. A pharmacist visited four times a year to undertake medicine checks and audits.
- Child visiting did not take place at the service.

Track record on safety

- We were informed of two serious incidents in the previous twelve months. The provider had not conducted an investigation into the first incident, which involved a patient death. However, the local authority safeguarding team had conducted an investigation. They learnt that the speech and language therapist (SALT) for the service was not competent in assessing

dysphagia (swallowing) or eating and drinking problems. The Royal College of Speech and Language Therapists have developed standards for competency in this area (Dysphagia Training & Competency Framework, Royal College of Speech and Language Therapists, 2014). The SALT had not been assessed as meeting the standards. The provider had developed an action plan from the local authority safeguarding investigation. The action plan was for the same SALT to review policies and guidance and provide training to staff. The SALT was also to identify patients with eating and drinking problems and assess them.

- The second incident involved a patient not receiving treatment for a serious injury for several days. The provider and the local safeguarding team conducted investigations into the incident. As a result of this incident, changes were made to the patient's care. However, learning from this incident was not used to minimise the risks for other patients.

Reporting incidents and learning from when things go wrong

- In the six months before the inspection between 18 and 71 incidents were reported each month. There had been 206 incidents in total. Ten (5%) of the incidents were classified as serious. Physical assaults accounted for 139 (67%) incidents. Twenty-five incidents (12%) were assaults on staff. Five patients were recorded as being the victim of assault in the previous three months. Incidents were broken down into 15 categories. There were no categories for medicine errors or staff shortages. However, staff told us that medicine errors were reported as incidents.
- Not all incidents were reported. Staff told us of daily incidents involving patients being aggressive. This consisted of patients throwing objects, damaging property or attempting to assault staff. Staff appeared to accept a high level of violence. There were no incident forms regarding staff shortages. We were told that there were staff shortages on a weekly basis.
- When mistakes were made, staff reported these to the management team. The operations manager understood that the patient should receive an apology. However, there had been some mistakes recently in the service. These were mistakes that could have caused serious harm. There was no record that any of the staff team attempted to apologise to the patients.
- There was no system to feedback to staff the outcome of incident investigations. A review of incidents was not a standing agenda item at the team meeting. When staff did receive feedback it was brief and ad-hoc feedback. This involved staff being told of changes required following the investigation. Staff were not involved in any discussion of the incident.
- Staff did have de-briefing sessions following incidents. However, this was inconsistent and did not always occur. Staff did not complete the debriefing form consistently. It was not possible to know which staff had attended or the details of the discussion. Learning points from the debriefing were not recorded.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- Before patients were admitted to the hospital they had an initial assessment. Most patients would be visited by a staff member at home or with their present health provider. This was for staff to assess the patient's needs and risks. However, staff were unable to visit patients who were admitted as an emergency.
- We looked at the clinical records of ten patients. All patients had a thorough assessment by a doctor when they were admitted to the service. Patients also had a psychological assessment undertaken by an assistant psychologist. This involved a functional analysis of the patient's behaviour. This is a way of understanding why a patient behaves the way they do. Undertaking such an assessment was in accordance with national guidance (Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NICE, 2015b). However, the assessment process did not include an 'in-depth assessment involving interviews with family

members, carers and others, direct observations, structured record keeping, questionnaires and reviews of case records', which national guidance recommends (NICE, 2015b). Patients also had an assessment of their skills for daily living. The domestic activities of daily living (DADL) and personal activities of daily living (PADL) assessment tools were used. Patients also had an assessment of their communication. A communication and observation checklist was used. These assessments were undertaken by occupational therapy and speech and language therapy assistants. Psychological, communication and daily living skills assessments were not supervised or countersigned by qualified staff.

- Patients had their physical health care needs managed by a local general practitioner (GP). Patients registered with the GP shortly after admission. However, patients did not have an annual physical health check. This was not in accordance with national guidance (NICE, 2015b). The monitoring of patients' physical health was not consistent. One patient's care involved weighing the patient each morning. This had occurred 14 times in the previous year. Another patient had been diagnosed with diabetes. The diabetic nurse's advice was not followed. A patient had recently had a plaster cast on their arm following an injury. A hospital leaflet provided details of checks that needed to be undertaken. These had not been done.
- Each patient had a document called 'my life story'. This provided staff with information on the background of the patient, their likes and dislikes. This was completed by the patient or, in some cases, their relatives or staff.
- Each patient had a number of care plans. Patients who had difficulty reading had some care plans with pictures. However, the same pictures were used for each patient. These care plans did not cover all of the patients' areas of need. Most care plans lacked specific details. For instance, one patient's care plan said 'blood sugar levels should be within therapeutic range'. The actual range was not recorded. If the patient's blood sugar level was out of normal range, there was no guide on what action to take. The care plans for patients with autism did not record the patient's needs for structure and routine. They did not record patients' hypersensitivities. These are important elements of care planning for patients with autism (Autism: recognition, referral, diagnosis and management of adults on the autism spectrum, NICE, 2012). Care plans were not recovery focussed. There were few short-term and long-term outcomes or goals. Care plans were not time limited and there was no date for the care plan to be reviewed. The majority of care plans were not signed and dated by staff. Care plans regarding patients' challenging behaviour appeared to be written for staff rather than the patient. Patients had care plans for physical interventions. These were not care plans, but instructions for how staff were to restrain the patient. One care plan had been written two years previously. The date had been crossed out each year and a new date added.
- Each patient's care and treatment records were stored in three files. The size of the files made finding some documents difficult. We found over 20 documents which were in the wrong patients' records. This meant not all of the information for a patient was immediately available to staff. There was also a range of documents which did not contain the patient's full name. To establish which patient it related to, it was necessary to read the document. Some documents in patients' records were completed and not signed by staff. Other documents were not fully completed. Sections of some documents were left blank. This included important areas such as part of a patients' 'my life story'.

Best practice in treatment and care

- Antipsychotic medicines were not used routinely. This was in accordance with national guidance (NICE, 2015b).
- For patients with a learning disability there was an activity programme. However, this was not always personalised. Patients' interests and capacity were not always reflected in activities. This was not in accordance with national guidance (NICE, 2015b). For instance, groups of patients regularly went out in the service minibus for 'a drive'. The purpose of this activity was unclear. Documents that recorded the activity of each patient, each day, were not always completed. This meant there was no record of how often patients had undertaken, or refused to undertake, an activity. This limited the effective monitoring of patients' behaviour. Activities did not focus on building the skills of patients to cope more easily with difficult situations. However, the assistant psychologists worked individually with some patients regarding their aggression. They also provided relaxation sessions. These were offered in

accordance with national guidance (2015b). Some patients had significant sleeping problems. These had not been assessed using functional analysis. There was no care plan addressing sleeping. There was no structured bedtime routine. This was not in accordance with NICE guidance (2015b). Half of the patients in the service had autism. Their potential elevated anxiety levels were not always addressed. There was no consistent ongoing assessment of how patients would tolerate a specific intervention. There was no record that blackout curtains or providing patients with earplugs had been considered. The colours of walls and furnishings were not calming (NICE, 2012). Some patients with autism had picture exchange communication system (PECS) cards. However, these were not used consistently. Patients also had emotions charts, and 'reward' charts to reinforce positive behaviour. The consistency of patients' care was affected by the high turnover of staff. Staff learnt how to minimise risks and care for patients from each other rather than patients' clinical records.

- Patients were able to access specialists for their physical health needs. Most specialists were accessed via the GP. However, patients also visited the dentist regularly.
- The service used health of the nation outcome scales – learning disabilities (HoNoS-LD) as an outcome measure. The behaviour problems inventory-short form (BPI-S) was also used as a rating scale for patient behaviours.
- Audits of patients' care and treatment records were due to be undertaken monthly. Three audits had been undertaken since 2011. They had all been undertaken in a period of six weeks. The audit recorded that both wards and Ivy Mews had been audited. There was no record of which patients' records were audited and the findings. A member of staff undertook a regular infection control audit. A medicines audit was undertaken quarterly.

Skilled staff to deliver care

- The multidisciplinary team (MDT) included a speech and language therapy assistant and two assistant psychologists. The speech and language therapist attended the service two days per week. The assistant psychologists received supervision and guidance from a clinical psychologist. However, the clinical psychologist did not visit the service. This meant they did not know the patients and that there was no psychologist in the MDT. Registered nurses in both mental health and learning disabilities and an occupational therapist were also part of the MDT. There was no pharmacist or social worker in the MDT.
- Staff had an induction when they started employment. This involved one week of orientation and training. Following this staff briefly shadowed colleagues and then began working shifts. Further training took place during the first six weeks of employment.
- Staff received monthly supervision and annual appraisals. A number of staff had recently started working at the service and were not due an appraisal for several months.
- Some staff had undertaken additional specialist training. However, rates of staff training were low. Four staff (8%) had undertaken training to support patients to develop skills. The same number of staff had undertaken Makaton sign language training. Eight staff (15%) had undertaken suicide prevention training and 'valuing people' training. Seventeen percent of staff (nine staff) had attended communications training. Half of the patients at the service had autism. Fourteen staff (27%) had undertaking training in aspergers and autism. National guidance states that all staff working with such patients should have a good understanding of autism (NICE, 2012). Fifteen staff (29%) had attended training on dysphagia, choking and oral hygiene. Several patients had swallowing difficulties. Fifteen staff (29%) had training in mental health conditions.

Multi-disciplinary and inter-agency team work

- There were monthly MDT meetings for each patient. These meetings were not frequent enough to review and monitor the care of patients with multiple, complex needs. MDT meetings often consisted of the consultant psychiatrist, a nurse and the assistant psychologist. The effectiveness of the MDT meetings was limited by other MDT members not attending.
- The MDT did not function effectively. Some staff worked effectively on an individual basis. However, there was a lack of overall day-to-day clinical leadership in the service. The ability of the MDT to meet patients' needs was limited. This was partly due to the lack of a clinical psychologist in the MDT.

- Handovers between the day and night nursing shifts lasted for 30 minutes. The handover for each patient was brief. It mainly consisted of a description of the patient's activities. General terms were used, such as the patient being 'settled'.
- Working relationships with other agencies were not always good. Other agencies had considered it necessary to inform the provider of their concerns regarding patients' care and safety. One agency had raised a safeguarding alert concerning the standard of care being provided to a patient.

Adherence to the MHA and the MHA Code of Practice

- Ten staff (19%) had received training in the MHA. However, six of these staff had only received training regarding Section 58 MHA. MHA training was not mandatory for staff.
- Patients had their capacity assessed regarding medicines. Some patients did not have the capacity to consent to treatment. The appropriate authorisation (T3) certificates were available for these patients. One patient received medicines three months after admission without a consent (T2) or authorisation (T3) certificate. This had continued for 19 days until the inspection. The date that a certificate was required had been miscalculated. Another patient was subject to Section 62 emergency treatment. The provider had not requested a second opinion appointed doctor (SOAD) until shortly before the end of the patients' first three months.
- Patients had their rights under MHA explained to them on admission to hospital. This was repeated every two months. Patients were provided with information about their rights in an 'easy read' format. A number of Mental Health Review Tribunals had taken place in the previous year.
- The service did not recognise that the care being provided to one patient constituted long-term segregation. Reviews of long-term segregation were not carried out in accordance with the MHA code of practice. There was no record of how the service was working with the patient to end the use of long-term segregation.
- Paperwork relating to the detention of patients was in good order. It was completed correctly and stored appropriately.
- The provider had access to a MHA professional who worked for them when required. An audit was undertaken regarding mental health review tribunals and managers hearings. There were no other audits.
- Information was displayed on noticeboards regarding the independent mental health advocate (IMHA). Two patients had an IMHA.

Good practice in applying the MCA

- Nineteen percent of staff had received training in the Mental Capacity Act. MCA training was mandatory.
- Four deprivation of liberty safeguards (DoLS) applications had been made in the previous six months. On application was invalid as the patient was already detained under MHA.
- Staff had a very limited understanding of the MCA. They could not describe the five principles or the capacity test.
- The providers MCA policy consisted of one page. It did not describe the five principles or the role of the independent mental capacity advocate. The importance for all staff to understand the MCA was not highlighted. The policy contained general comments with minimal detail.
- The provider had standard forms to record assessments of patients' capacity. Completed forms documented the details of the capacity assessment.
- There was very little evidence that patients had been supported to make their own decisions. No decisions had been delayed to attempt to support the patient to make the decision. Patients were not supported by an independent mental capacity advocate (IMCA) when important decisions were made. Capacity assessments and decisions were only made during ward round.
- Most DoLS applications were made when appropriate. However, one patient had been the subject of a DoLS application over one year previously. The provider had contacted the supervising body one month after the application was made. The supervising body explained that there were delays. The provider had not contacted the supervising body after this and no DoLS assessment had taken place. Shortly before the inspection, in a psychology progress report, the patient's legal status was recorded as informal. However, the patient

Inadequate

Wards for people with learning disabilities or autism

remained subject to significant restrictions. A care plan discussed action to be taken if the patient's leave was cancelled. The patient remained deprived of their liberty without lawful authority for over one year. We informed the provider and supervising body of the situation, and made a referral to the safeguarding team. The supervising body took immediate action. The patient was subsequently detained under the MHA.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, dignity, respect and support

- Overall, staff were observed to have a relaxed approach with patients. They listened to patients and responded to their needs. Some staff spoke enthusiastically about patients and displayed warmth and understanding. However, staff members approach was not always appropriate. We observed one patient being told 'sit down or go to your bedroom'. Some progress notes in clinical records referred to patients 'playing up'. This indicated some staff had a paternal attitude towards patients.
- Overall, patients were positive regarding the staff. They described the staff as 'lovely' and 'helpful'. However, one patient felt bullied by the staff. Before the inspection a comment box had been placed in the service. We received seven comment cards from patients. All of the comment cards were positive and praised staff.
- Most staff had a limited understanding of patients' needs. They had limited opportunities to discuss patients in depth.
- One of the internal CCTV cameras pointed directly into a female patients' bedroom. The patients' bed could be seen on the CCTV monitor. This was not in accordance with the provider's policy. When we raised this with the provider, the CCTV viewing angle was immediately changed. Virtually none of the patients had curtains or blinds in their bedroom.

The involvement of people in the care they receive

- Most patients did not contribute to their care plans. The care plans simply stated that the patient had not contributed or could not communicate. There was no further explanation. There was no description of patients who could not verbally communicate being assisted to contribute to their care plan. None of the patients had a copy of their care plan. Patients had limited input into MDT and care programme approach (CPA) meetings. Their views were not consistently recorded.
- For patients not detained under the MHA the service had access to an independent advocacy organisation.
- Carers and relatives were invited to patients CPA meetings. They also spoke with staff when they visited or contacted the service. Feedback from relatives was mixed. There were some issues regarding how relatives were listened to. Changes to patients' care, as a result of their feedback, did not always happen. When they did, it took some time.
- A community meeting for patients was held every month. However, there had recently been a period when a community meeting was not held for four months. At the community meeting patients fed back their views on the service. They also discussed the difficulties of living together. Notes of the meeting were recorded but were not displayed in an area patients could read them. Patients were told their views would be passed to the service managers. There was no record that action was taken as a result of patients' views. Patients raised some of the same issues at every community meeting. A patient survey was conducted in 2015. Ten patients responded. Some patients responded to parts of the survey. Two patients provided only positive responses. Six patients provided positive and negative responses. There was no record of any action taken as a result of the survey.
- Patients were not involved in any decisions about how the service operated.
- None of the patients had advanced decisions in place. These are a record of how the patient wants to be treated if certain situations arise.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Inadequate

Wards for people with learning disabilities or autism

Inadequate

Access and discharge

- In the previous six months bed occupancy was 74%.
- Most patients were admitted to the hospital from other services. These ranged from residential services to low secure units. These admissions were planned in advance and happened shortly after agreement had been made to admit the patient. Some patients were admitted from the community or police stations. In some cases, these were urgent or emergency admissions. When patients were admitted as an emergency, the service did not always receive information about the patient until their arrival. This affected the ability of the service to meet all of the patients' needs when they were admitted.
- The average length of a patient's admission was 18 months to two years. Four patients had been at the service for over two years. Two of these patients had been admitted for four years. There was little progress in these patients' care and treatment. They did not have clear discharge plans.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a limited range of rooms in the service. There was one communal area in Bloomfield Court which was the lounge and dining area. Jasmine Court had a separate lounge and dining room. There was a visitor's room for the service. Patients were also able to have a visitor in their bedrooms.
- There were separate gardens for Bloomfield Court and Jasmine Court. Each of the flats in Ivy Mews had a small garden. Patients could access the garden at any time.
- Bloomfield Court and Jasmine Court appeared institutional. The walls were bare with no pictures or shelves. There were a small number of documents attached to the wall. These were placed high up on the wall. The environment was not well looked after and did not promote comfort and recovery.
- Patients were able to have drinks and snacks at any time of the day or night. However, patients did not have access to the kitchen and needed to ask staff for these.
- Patients were able to personalise their bedrooms. Some patients had a number of personal items in their bedrooms. Other patients had minimal personal effects.
- Following risk assessment, some patients had keys to their bedrooms. Other patients' bedrooms were left unlocked so that they could go to their bedroom when they wished. This meant some patients' possessions were not stored securely.
- Activities were available seven days a week.

Meeting the needs of all people who use the service

- The service was wheelchair accessible and had some ground floor bedrooms. One patient used a wheelchair to mobilise.
- There was no information available or displayed regarding complaints, helplines, advocacy, metal health problems or treatment.
- There were no patients in the service who required a translator. A small number of staff had undertaken makaton communication training. Where a patient required an interpreter we were told this would be arranged.
- The patients' menu consisted of meals high in calories and carbohydrates. There was limited fresh fruit and vegetables. A number of patients had significant weight gain since being admitted to the service. However, some patients had specific diets. These included pureed food for a patient at high risk of choking and a gluten free diet. Some patients had meals in accordance with their faith.
- Patients were supported to practice their faith. This included patients being escorted to a place of worship.

Listening to and learning from concerns and complaints

- There were seven complaints in the previous 12 months. The complaints related to noise, staff abuse, staff attitude and verbal abuse and threats. None of the complaints were upheld.
- Staff were aware that formal complaints should be directed to the manager. However, most patient concerns were dealt with informally.

Inadequate

Wards for people with learning disabilities or autism

- Complaints were not a standing agenda item at the team meeting. The service did not monitor formal complaints or informal concerns to identify themes and trends. This meant ongoing difficulties may not be identified.

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

Inadequate

Vision and values

- The provider had published a vision statement. This explained the providers' values.
- Staff knew who the senior managers in the organisation were. They visited the service regularly. The area operations manager spent a significant amount of time at the service.
- Different managers had different views regarding the purpose of the service. It was described as an assessment and treatment service and separately, as a rehabilitation service. It was also described as undertaking both roles. The confusion regarding the identity and the role of the service affected patient care and safety.

Good governance

- The systems and processes in the service were not effective. They did not effectively assess, monitor and improve the safety and quality of the service. Risks were not appropriately identified, monitored and mitigated.
- The average completion rate for staff mandatory training was low. Staff did not consistently receive the training they needed to undertake their role.
- Staff received regular supervision. Appraisals took place annually.
- There were not enough registered nurses to ensure that all patients received safe and high quality care. A significant proportion of shifts were not fully staffed. This was an ongoing problem.
- Nurses spent the majority of their time on administrative tasks. Work was not organised so that nurses could spend most of their time with patients. This affected safety and the quality of care.
- Not all incidents were reported. When they were, most incident forms were not fully completed. This limited the amount of information available to improve safety.
- The system for monitoring patients' physical health was not consistent or effective.
- Three clinical audits were undertaken; one was undertaken regularly but was not fully effective. Another was not undertaken regularly. The health and safety audit had not been undertaken for several months.
- Staff worked excessive hours. They had insufficient breaks during their shifts.
- There was no system for all staff to learn from complaints, incidents and patient feedback.
- Safeguarding, MHA and MCA procedures were not followed. Referrals to the local safeguarding team were delayed. A patient was subject to long-term segregation without the safeguards of the MHA code of practice. A patient had been subject to deprivation of liberty without lawful authorisation for over one year.
- The provider had 22 key performance indicators. These related to the number of staff vacancies, safeguarding referrals and outstanding health and safety issues. Some Care Quality Commission regulatory actions and actions from audits were included. The information from the indicators was limited because of a lack of detail. For instance, the number of staff supervisions in the month could be recorded as 'four or more'. Similarly, training completed could be 'two or more'. This information contributed little to the assessment of service performance.
- There was no administrative support for either the manager or the multi-disciplinary team.

Leadership, morale and staff engagement

- The service had five managers or acting managers in the three years before the inspection. At the time of the inspection, there had been no registered manager for almost eighteen months. The deputy manager had recently been appointed the acting manager.

Inadequate

Wards for people with learning disabilities or autism

- The staff sickness rate in the previous year was 2%.
- There were no cases of staff bullying and harassment in the previous year.
- Staff were able to raise some concerns during regular team meetings. However, some staff did not know how to respond if they observed or heard about poor care, neglect or abuse. This meant patients were not fully protected from harm.
- Overall staff members reported good morale and job satisfaction. However, minutes of the team meetings did not reflect this. Staff requested improvements, consistency and training. The minutes reflected divisions in the staff team Staff also queried the support of the management team.
- The management team were out of touch with day-to-day events in the service. For instance, the acting manager did not know that an activity room had been changed into a storeroom. There was little understanding of the extent of the improvements required in the service. Issues with team building, communication and standards of care were not addressed effectively. Established governance systems and provider policies were not used effectively. The acting manager had a defensive, directive, top-down style of leadership. The management team did not have the knowledge, skills or capability to manage the service safely and effectively.
- Immediately prior to the inspection, the provider had appointed a new director of operations. A new, interim, operations manager had also been appointed. They would oversee services including Bloomfield Court and 5, 6 Ivy Mews. The new senior management team clearly understood the challenges at the service. They responded quickly and appropriately to concerns that we raised.

Commitment to quality improvement and innovation

- The service was not involved with any national improvement or accreditation schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is an appropriate level of consultant psychiatrist input in the service.
- The provider must ensure that dysphagia, and eating and drinking assessments, are undertaken by a person assessed as competent to undertake such assessments.
- The provider must ensure that there is an appropriate level of direct input into the service from a clinical or counselling psychologist.
- The provider must review the number of registered nurses on each shift.
- The provider must repair or replace the kitchen refrigerator used to store food for patients, as soon as possible.
- The provider must ensure that patient's risk assessments are appropriately detailed. They must contain appropriate primary and secondary strategies and be reviewed regularly.
- The provider must ensure that the level of observation of patients reflects their level of risk. Staff must not provide continuous support and observations for a prolonged period of time.
- The provider must ensure that all patients have an annual physical health check.
- The provider must ensure that all staff are aware of situations which place potentially vulnerable adults at risk. Safeguarding referrals must be made appropriately and without delay.
- The provider must ensure that where patients are deprived of their liberty, that they are lawfully detained.
- The provider must ensure that all staff have appropriate training so that they have the skills and knowledge to undertake their role.
- The provider must ensure that care plans are person-centred and meet all of the patients' needs. Patients must be involved in decisions regarding their care.
- The provider must ensure that all staff treat patients with dignity and respect. When restrictive interventions are used, the MHA code of practice must be followed. Patients must be afforded privacy to the maximum extent possible.
- The provider must ensure that the service is clean and well maintained. The environment and décor must promote comfort and recovery.
- The provider must ensure that there are effective systems and processes to assess, monitor and improve the quality care. Systems and processes must also effectively assess, monitor and mitigate risks. Patients must have a complete set of care and treatment records, appropriately identified and signed.

Action the provider SHOULD take to improve

- The provider should implement a restrictive interventions reduction programme as soon as possible.
- The provider should ensure that patients are offered healthy, balanced meals with fresh produce.
- The provider should ensure that there is strong leadership 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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of patients was not appropriate, did not meet their needs, and did not reflect their preferences. Care and treatment was not designed to ensure patients' needs were met. Patients were not supported to understand treatment choices or make decisions about their care to the maximum extent possible. Patients did not have care plans for all of their needs. Patients were not supported to understand their care and treatment choices. Patients did not participate in making decisions about their care or treatment. This was a breach of regulation 9 (1)(b)(c)(3)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patients were not always treated with dignity and respect. The provider did not always ensure the privacy of patients. A comment from staff and some care and treatment records indicated that patients were not always treated with dignity and respect. A patient subject to long-term segregation was not reviewed according to best practice. A CCTV camera pointed directly into a female patients' bedroom. Most patients' bedrooms did not have curtains or blinds on the windows. This was a breach of regulation 10 (1)(2)(a)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Premises were not clean or properly maintained. They were not secure or suitable for the purpose for which they were being used. Standards of hygiene were not maintained. There were stains on walls, cobwebs and dirty mirrors. Surfaces around sinks, baths and toilets required replacement. There was worn and torn carpet on the stairs. There was a limited range of rooms in the service. The two ward areas appeared institutional. The walls were bare with no pictures or shelves. The environment was not well looked after and did not promote comfort. This was a breach of regulation 15 (1)(a)(b)(c)(e)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively to assess, monitor and improve the quality and safety of the service provided. They did not assess, monitor and mitigate risks to the health, safety and welfare of patients. Patients did not have an accurate, complete and contemporaneous record of their care and treatment. The care and treatment record and infection control audits were not effective. There was no system to learn from and act on patient feedback. There was no system for staff to learn from complaints, incidents and patient feedback. The system for incident reporting was not effective. Key performance indicators were of limited use in assessing the quality and safety of the service. Patients did not have a full set of care and treatment records. This was a breach of regulation 17(1)(2)(a)(b)(c)