Walkern Lodge

Quality Report

14a Walkern Road
Stevenage, Hertfordshire SG1 3QX
Tel:01438 360501
Website:www.cambiangroup.com

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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

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.

Overall summary

From our inspection we found:

- The provider was not providing safe care and treatment.
- Staffing duty rotas showed there were often not enough staff. In one three-week period, 15 nursing shifts were short staffed.
- The provider did not have robust governance systems in place to consistently assess and monitor the quality of the service. We found gaps in patient and management records for risk assessments, safeguarding and incident investigation. Staff were not receiving regular training and support for their role.
- Staff had not carried out adequate assessments of risk for individual patients under their care and care plans were not updated.
- There were environmental risks. The service had no dedicated cleaning staff. Some areas were not clean and this posed a risk that patients and others may get an infection. Two bedroom floors had water from the shower overflow, which posed a risk of people slipping.
- We found risks regarding medicines management practice. Actions by the provider after a pharmacy audit were incomplete.
- Patients' files did not have key Mental Health Act 1983 and Mental Capacity Act 2005 documents. For example, the record for the renewal of section for a patient after November 2014 was not in the patient's file.

Summary of findings

- Current complaints records were not available and we had concerns that the provider was not responding to patients' concerns raised.
- There had been three managers since May 2015. There had been significant changes to the core staffing and management in the last year. This had affected staff morale.

However:

- A new part time manager from another hospital had just started working at Walkern Lodge. A regional director with oversight of this hospital and others in the area had taken action to ensure manager was available for the hospital.
- Staff used nationally recognised assessments such as the short-term assessment of risk and treatability (START) assessment tool as part of their initial and on-going assessment of risk.
- Staff had ensured that patients who needed higher levels of observation had bedrooms on the ground floor. Staff had easier access to observe and support them if they became unsettled.
- Staff supported patients to keep contact with their family and friends.
- Patients could contact independent advocates as required to help communicate their needs.
- Patients personalised their rooms. Pictorial information and sensory, sound and light objects for patients' stimulation were available.

Following this inspection, we identified that the provider was not meeting Regulation 12, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this location. We carried out enforcement action with the provider and told them to ensure compliance by 13 October 2015. The provider sent us their action plan to meet the regulation and informed us they had plans to close the location by 31 December 2015.

Summary of findings

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Summary of this inspection

Background to Walkern Lodge

- Cambian Healthcare Limited provide inpatient learning disability services at Walkern Lodge hospital.
- Walkern Lodge is a six-bedded independent hospital for women with a learning disability or mental health needs who may be detained under the Mental Health Act 1983. The hospital is not purpose built and is a house set in the community. There were four patients receiving care and treatment and one newly admitted patient the day of inspection. All patients were detained under the Mental Health Act 1983.
- This location is registered to provide treatment for disease, disorder and injury and assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Walkern Lodge was last inspected in June 2013, there were no breaches of the Health, and Social Care Act 2008 (Regulated Activities) Regulations 2010 identified at that time.

A manager and controlled drugs accountable officer was not registered with the Care Quality Commission at the time of our inspection. The provider had plans in place to register the new covering manager for this.

Our inspection team

Our inspection team was led by:

Team leader: Kiran Williams, Inspector, mental health hospitals

The team included two CQC inspectors and an expert by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the location.

Why we carried out this inspection

We carried out a focused inspection of this location in response to concerns identified by the Care Quality Commission.

How we carried out this inspection

As part of the focused inspection we considered

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to patient's needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about this location.

During the inspection visit, the inspection team:

- Spoke with four patients who were using the service.
- Spoke with six staff members; including the interim manager.
- Reviewed four care and treatment records of patients.

Summary of this inspection

- Examined each medication recording card and carried out a specific check of the medication management.
- Inspected a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Two patients said that agency staff were regularly used. Three patients told us they did not feel safe living at the hospital because they alleged that other patients bullied them.
- One patient told us they were not sure what their treatment plans were for their mental health or physical health needs. Two patients said staff did not always give feedback when they restrained a patient. They also said they did not always understand why staff used restraint and they did not like it.
- Patients gave mixed feedback about activities on offer. Some were satisfied with the range, amount and frequency but others not.
- Three patients told us the environment could be noisy, with shouting and banging at times. However, we did not find this during our inspection.

However:

- Patients said there were staff they liked, who gave them support.
- Patients said they could contact independent advocates when they needed to and staff supported them to keep contact with their family/friends.
- Patients knew how to raise complaints and concerns.

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?

From our inspection we found:

- The service had no dedicated cleaning staff. Cleaning was the patients' responsibility with staff providing support. We saw several instances where areas were not clean. The lack of hygiene processes posed a risk that patients and others could gain an infection.
- Two bedroom floors had puddles of water from the shower overflow, which posed a risk of slipping. Patients had previously raised this concern at a community meeting on 05/05/2015.
- The duty rotas showed there were often not enough staff. In one three-week period, 15 nursing shifts were short staffed.
- Staff had not received adequate training. From information available for mandatory training as identified by the provider, staff attendance was low with overall 44% staff compliance for June 2015.
- Staff did not update three patients' risk assessments and care plans following risks and incidents.
- The hospital provided staff with personal alarms but staff did not use them. The provider did not maintain the alarms and this put the staff at risk.
- Staff did not fully complete patient and management records. For example, physical health checks were not documented as taking place after four incidents where patients had been given rapid tranquilization medication.
- A staff member told us they had not received the provider's restraint training and had been asked by staff to carry out restraint at times. This posed a risk that restraint would not be safe or appropriate.
- There was a lack of formal governance systems. Staff told us they did not have information relating to learning from incidents and actions taken to reduce the risk of reoccurrence. Following an independent pharmacy audit, actions relating to having a medication error log were not fully completed.

However:

- Patients had task specific risk assessments, which included a multi-disciplinary team (MDT) activity risk assessment screening tool (RAG) rated. Individual patient risk assessments for kitchen access took place.
- Patients had positive behaviour plans detailing how staff should give them support during incidents.

Summary of this inspection

- Staff had ensured that patients who needed higher levels of observation had bedrooms on the ground floor. Staff had easier access to observe and support them if they became unsettled.
- Following an independent pharmacy audit, the provider had taken actions, to improve storage, recording and disposal of medication.

Are services effective?

From our inspection we found:

- Staff did not update three patients' care plans following risks and incidents. This presented a risk that staff did not have up to date information to refer to when delivering care and treatment.
- Physical observations records for one patient were incomplete and did not state whether the patient had refused.
- Staff did not have consistent training and information for their role. For example, two staff had not received the provider's corporate induction.
- Patients' files did not have key the Mental Health Act 1983 and Mental Capacity Act 2005 documents. For example, the record for the renewal of section for a patient after November 2014 was not in the patient's file. One patient's assessment regarding their ability to manage finances was not available in the patient's file for staff to refer to delivering care and treatment.
- The provider had not regularly reviewed audits and actions plans for improvement, for example relating to health and safety.

However:

- There were systems for staff to explain to patients their legal rights under section 132 of the Mental Health Act 1983.
- Patients had some individual risk assessments and care plans for identified needs.
- Records showed that most patients' physical health needs were assessed and referred to arranging appointments for issues such as with a local GP.
- The provider used nationally recognised assessments such as the short-term assessment of risk and treatability (START) assessment tool as part of their initial and on-going assessment of risk.
- The multi-disciplinary team included nurses, support workers, consultants, psychology and occupational therapy staff.

Are services caring?

From our inspection we found:

Summary of this inspection

- Two staff members reported that staff did not have the skills to interact with patients. One patient told us staff could be abrupt and shout at them. We observed two occasions of staff abruptness and limited interaction with patients. We raised this with the manager who said they would take immediate action to address the concerns.
- Care plans did not capture how patients had been involved in the development of them.
- Two patients told us they did not always have feedback after restraint had taken place; were not sure why it had taken place and did not like it. Staff records did not detail if incidents were reviewed with patients afterwards.

However:

- We saw examples of positive staff and patient interaction and individual support. We saw that most staff treated patients with kindness and respect.
- Staff supported patients to keep contact with their family and friends.
- Patients could contact independent advocates as required to support them to communicate their needs.

Are services responsive?

From our inspection we found:

- Two staff said staff were not involved in pre admission assessments and had concerns about the appropriateness of some patients placements. Three staff said the criteria for admission had changed and patients admitted had more complex/challenging needs so incidents had increased.
- The hospital was not purpose built. Some downstairs corridors were narrow, which meant that staff could not walk down them if restraining patients and wanted to take them to their rooms for their dignity and privacy. Instead, staff and patients walked through the communal garden to enter bedroom patio doors.
- Patients gave mixed feedback regarding activities taking place, with some satisfied with the range amount and frequency and others not.
- Weekly community meetings minutes held limited detail and records did not always capture the provider's actions and timeframes for responding and resolving issues.
- Current complaints records were not available and we had concerns that the provider had not responded appropriately to patients' concerns raised.

However:

Summary of this inspection

- Patients were placed from various parts of the United Kingdom due to placements not being available in their home area to meet their needs. We saw that reviews took place with commissioners to consider if the placement was still appropriate for the patient. Patients had identified care pathways.
- The provider said there were no delayed patient discharges and two patients had identified placements to move to.
- The hospital had rooms where patients could relax and watch television or engage in therapeutic activities.
- Patients personalised their rooms. Pictorial information and sensory tactile, sound and light objects for patient's activities and stimulation were available.
- Patients knew how to make complaints and staff told us they regularly did so. Weekly community meetings took place. The minutes showed that patients were encouraged to raise concerns and issues could be further raised in the monthly advocacy forum.

Are services well-led?

From our inspection we found:

- The provider's governance processes to manage quality and safety were not robust. Staff audits relating to health and safety were not regularly reviewed. Mechanisms for patients, staff and others to give feedback and for the provider to gauge the performance of the service were not consistent. There were gaps in records for risk assessments, safeguarding and incident reporting. Staff actions taken in response to concerns raised were not always documented.
- There was a lack of consistent leadership. There had been three managers since May 2015 and there was no registered manager at the time of the inspection. There had been significant changes to the core staffing and management in the last year. This had affected staff morale. Four staff said staff communication was affected in the team, for example, they did not have information for their daily roles or feedback from incidents.
- Staff were not receiving adequate training and support. Staff monthly supervision and annual appraisal were on average 50% compliant in the last six months. The covering manager and nurse in charge could not easily access management records for staff support and development to show us information.

However:

Summary of this inspection

- Staff were aware of whistleblowing processes and information was available to refer to.
- A new manager from another hospital had just started working there part time. A regional director with oversight of this hospital and others in the area had taken action to ensure management cover arrangements.

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.

- All patients were detained under the Mental Health Act 1983.
- Staff adhered to consent to treatment and capacity requirements and copies of consent to treatment forms were attached to medication charts where applicable.
- Staff had systems to regularly explain to patients their legal rights under section 132 of the Mental Health Act 1983 and record this. Patients had access to independent mental health advocacy services.
- Administrative support and legal advice on implementation of the Mental Health Act 1983 and its code of practice was available from a central team.
- Mental Health Act 1983 documentation for the renewal of section for a patient after November 2014 was not available in the patient record.
- Staff regularly completed audits for monitoring the use of section 58 and 60 authorisation of medication and treatment requiring consent or a second opinion.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Individual assessments were completed under the Mental Capacity Act 2005 where staff had concerns that a patient might have impaired capacity to give consent. Decision-specific examples included patients' capacity to make decisions regarding healthy eating and daily living skills.
- However, assessment records were not consistently completed. An assessment for a patient's ability to manage finances had not taken place. This was despite reference in their care plan as being required. Another patient had assessments for day-to-day decisions completed in 2014 and there was no evidence that staff had reviewed these or they were still relevant.

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- The hospital was not purpose built and it was not easy for staff to observe all areas of corridors and rooms. Some downstairs corridors were narrow. A fire extinguisher was poorly situated opposite a bedroom door which when opened partially blocked the corridor. This meant a person, could not walk by. The front door was locked with keypad access, with staff monitoring patients' leave access.
- We saw high-level ligature points, for example door closers and in the garden such as gates and hanging baskets, which could pose a risk to patients with self-harming behaviours. A ligature assessment updated in May 2015 referred to staff undertaking observation and relational security to manage the risk. There were no recent incidents regarding this.
- Window restrictors were in place and an assessment from July 2014 was available but not updated. It did not detail a downstairs bedroom window, which opened in excess of 10 centimetres, which could pose a risk if a patient tried to abscond through it.
- There were no dedicated cleaning staff with patients responsible for cleaning with staff support. We found two ensuite toilets that required intensive cleaning. A toilet seat was in an ensuite bathroom sink, which staff could not account for. Two handwashing sanitizers/gels were empty. The provider sent us their last quarterly infection control audit for March 2015 this had not been updated by staff. Staff meeting minutes for February, March and June 2015 showed that staff had raised concerns about cleaning processes over several months and actions were not apparent. The lack of hygiene processes posed a risk that patients and others could gain an infection.
- A bedroom ensuite toilet was disconnected and placed in a vacant bedroom. Two bedroom floors had puddles of water from the shower overflow which posed a risk of patients or others slipping. One ensuite bathroom door had low-level brown damp. Low-level mould was on three bathroom floors, and the floor lining was lifting. A low level, damp patch was on an external wall to this bedroom area. Patients raised the flooding at a community meeting on 05/05/2015 and minutes detailed staff took some action.
- There were storage difficulties with two unused bedrooms used to store management records and patients' belongings. During the inspection, staff had to move items from one bedroom to another so a new patient could move into a bedroom. One patient had possessions overflowing on the floor, which could have posed a trip hazard. Staff had assisted the patient to get storage boxes to tidy this. The provider had systems to safely store the control of substances hazardous to health (COSHH). Equipment such as fire extinguishers and first aid boxes had been checked by staff and were in date.
- Food hygiene checks took place by staff. However, an unlabelled fish pie was in the fridge, so it was unclear if it was safe to eat. We bought this to staff's attention who took said they would take action to address this.
- The medication clinic space was small. This meant staff could have their back to patients sitting outside in the hall when in the clinic. Boxes were piled on the cupboard spaces and shelves were cluttered. The clinical room entrance was near the hall area where patients sat. A recent pharmacy audit had identified this as a risk and there were no actions identified by the

provider. The provider's monthly health and safety audits did not identify this risk and we had concerns that the provider was not robustly assessing and monitoring the environmental risks.

- Staff were not using the personal alarms available and they were not being maintained by the provider. This was despite three risk incidents since June 2015 with staff alone in a room with a patient posing a risk to their safety. Information was not available about the subsequent review of the incident with actions/learning points to reduce the risk of reoccurrence.

Safe staffing

- The provider had systems in place to determine staffing levels according to patients' need.
- All staffing rotas were not available on site. We requested the last three months of staffing rotas from the provider and were given them from 1 June 2015 onwards with gaps in records for June 2015. Rotas were not accurate and did not detail if bank or agency staff were used which the provider sent us later after our request. The provider confirmed that rota's were not completed fully. For three weeks from 27 July 2015 records showed that qualified and support worker staffing was below management-identified levels. Staff allocation sheets confirmed this. This posed a risk that there were not enough staff to support patient's needs. At our inspection, staffing levels were above management-identified levels with permanent and agency staff used. Additionally two new supernumerary staff and the manager were on site. Three staff reported staffing concerns relating to working below agreed staffing levels and high use of agency staff. Two patients said that agency staff were regularly on shift.
- Three staff reported a lack of staff affected activities regularly taking place. Patients had individual timetables, but activities were not all taking place the day of inspection. The provider stated that all patients used daily community leave outside the hospital. One patient went on a trip outside the hospital during our visit. Records showed that patients had access to community leave trips. Details of activities delivered by staff to patients were not available from the provider.
- Staff referred to regular bank night staff used. Three staff referred to a high staff turnover. The provider stated there were low levels of staff sickness. Three support workers and one nurse had left recently which was significant given the small group of staff. A nurse, senior support worker and five new support workers were recruited. Psychiatrists were not always on site but visited twice a week and could be contacted by telephone in an emergency. Patients were registered with a local GP surgery next door who could be contacted for physical health issues.
- Staff team meeting minutes showed that staff compliance overall with mandatory training as identified by the provider, was 44% for June 2015 indicating this was lower than expected but did not give further details. We requested further training information from the provider, which was not provided. Therefore, we could not be assured that staff had adequate training to provide safe care and treatment to patients.

Assessing and managing risk to patients and staff

- Staff risk assessment practices were inconsistent and we considered this posed a risk to patients or others. Individual risks assessments were completed for all patients. However, staff had not updated three patients risk assessments and care plans following risks or incidents. For example, two patients had an increase in risk for aggression towards others. A new patient was admitted and there were safeguarding issues identified with no identified management plan. Two staff expressed concerns at this. Two patients were identified as at risk for swallowing batteries and staff management of items were inconsistent. We found batteries in sensory lighting in the communal dining area and brought this to staff's attention and they were removed. Staff were supervising the communal television remote control access but patients had TV remote controls in their bedrooms. Patients had task specific risk assessments, which included a multi-disciplinary team (MDT) activity risk assessment screening tool. However, a new staff member had not received an adequate handover for a patient placed on red level (high risk) regarding their change in risk.
- Patients had positive behaviour support plans detailing how staff should give them support during incidents. Incident forms available showed staff had used restraint. A staff member told us they had not received the provider's restraint training and had been asked by staff to carry out restraint at times. This posed a risk that restraint would not be safe or appropriate. In February 2015, the provider stated that all staff apart from two

were trained and actions were being taken for all staff to receive new training. The provider despite our request did not make updated information on staff use of restraint and training available. For two restraint incidents in August 2015, the rationale was not clearly detailed.

- Physical health checks were not documented as taking place on four occasions after patients had been given rapid tranquilization medication and we were not assured that patients were regularly being monitored.
- After July 2015, staff had not completed behaviour analysis records to identify triggers for patients' risk behaviours. The provider had identified this as being required to help staff support patients to reduce the risk of incidents occurring.
- There was no identified seclusion room and staff said seclusion was not used. Staff said they may restrain a patient and for their dignity and privacy move them to a low stimulus area. Patients who needed higher levels of observation had bedrooms on the ground floor. Staff had easier access to give support if patients became unsettled or needed restraining. Staff assured us that patients' bedrooms were not used for seclusion.
- Nine patients' enhanced observation records in August 2015 were incomplete, for example with missing staff signatures or entries. On two occasions in the morning and afternoon of our inspection, staff did not update records but we saw that staff had been observing patients.
- The provider had some systems for safe medicines management practice, the monitoring of stock medication and staff audited medication reconciliation weekly. We found examples of doctors emailing prescriptions and one where staff did not update the patient's medication record in line with the provider's policy. A recent undated independent pharmacy audit had identified that the provider achieved 45% low compliance with the standards set by the pharmacist as good practice. After the pharmacy report, actions not completed included having a system for recording medication errors.
- Staff reported safeguarding training and we saw some systems to report incidents via local procedures. However, two staff were unclear about how safeguarding issues were dealt with. Three patients told us they did not feel safe living at the hospital because they alleged that other patients bullied them. We found three examples where patients had raised concerns about abuse and could not find that staff had taken actions to safeguard them. There were no safeguarding referrals since May 2015 despite a notification on the 1st of August 2015 to the CQC regarding an incident. We raised this for the manager's attention and they said they would take action on this to ensure reporting to the local authority and CQC. For another incident, the provider had sent us a notification but the provider's initial incident form was not available. Which meant reporting procedures were not followed.
- Blanket restrictions for patients not having keys to their bedroom were in place. Risk assessments were not available and staff could not explain the reasons for this practice and said this would be reviewed.
- Staff kept their personal bags in the kitchen despite the provider's guidance of keeping personal possessions in lockers available. This posed a risk that patients had access to staff's personal items.

Reporting incidents and learning from when things go wrong

- Whilst we saw that staff were reporting incidents using the provider's reporting systems and these were being reviewed by the manager, formal governance systems were not taking place for ensuring consistent incident reporting and reviewing of them. For example, staff we spoke were not given feedback relating to learning from incidents and actions taken to reduce the risk of reoccurrence. Two staff referred to learning from incidents informally from peer feedback and not via formal team meetings or governance meetings.
- Staff told us that a patient had thrown concrete garden slabs at staff. Staff had moved the slabs to the front garden to reduce the risk. A previously completed annual health and safety audit and monthly health and safety checks from February to April 2015 had not identified this as a potential risk.
- A recent incident had occurred where a patient accessed a knife from an unlocked sharp cutlery kitchen drawer. The kitchen was found locked at the inspection and individual patient risk assessments for kitchen access took place. We found that sharp cutlery was secure but staff daily safety checks were not recorded from 30/08/2015. The provider said a serious investigation led by another manager was still taking place into this incident.

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Patients had some individual risk assessments and care plans for identified needs.
- Staff did not update three patients' care plans following increased risks. This presented a risk that staff did not have up to date information to refer to when delivering patients care and treatment.
- Posters displayed at the location referred to patients having individual 'communication passports'. These were not available. This posed a risk that staff did not have information to refer to when delivering care and treatment.
- Staff supported patients to access annual health checks and with health care needs specific to the medical conditions associated with learning disability. Appointments were made for example with a local GP. However, one patient's physical observations records were incomplete and did not state if they had refused.

Best practice in treatment and care

- Staff had used nationally recognised assessments such as the short-term assessment of risk and treatability (START) assessment tool as part of their initial and on-going assessment of risk. Staff had completed the Glasgow coma scale and adult modified early warning score (MEWS) form, for one patient following restraint and rapid tranquilisation to monitor their physical health but these assessments were not routinely used.
- Staff had carried out some audits to assess and monitor the quality of the service given, for example relating to information governance. However, audits carried out by staff with actions plans for improvement, for example relating to health and safety, were not regularly reviewed. Therefore, systems were not robust.

Skilled staff to deliver care

- The multi-disciplinary team included nurses, support workers, consultants, psychology and occupational therapy staff.
- Staff were not consistently receiving training and information for their role. For example, two staff had not had received the provider's corporate induction. One was in post five months and the other was in post three weeks. Induction information available was for child and adolescent services, which did not relate to this service. Two staff said they had limited communication and information from staff about their roles and responsibilities. For example, one member of staff was not aware how staff were allocated tasks on shifts.
- During the inspection, two new staff were 'supernumerary' (not counted in staffing levels) and had the opportunity to shadow staff on shift and learn from them about the role.

Multi-disciplinary and inter-agency team work

- Staff referred patients to specialist assessments and treatment, for example dentist and opticians as required.
- Staff worked with some external agencies, such as with commissioners, community learning disability teams, police, and local authority. However, we had feedback from a commissioner that communication regarding changes to a patient's needs and care plan were not taking place as agreed. The provider was investigating this to respond to them.

Adherence to the Mental Health Act 1983 and the Mental Health Act Code of Practice

- All patients were detained under the Mental Health Act 1983.
- Staff adhered to consent to treatment and capacity requirements and copies of consent to treatment forms were attached to medication charts where applicable.
- Staff had systems to regularly explain to patients their legal rights under section 132 of the Mental Health Act 1983 and record this. Patients had access to the Independent Mental Health Advocacy services.
- Administrative support and legal advice on implementation of the Mental Health Act 1983 and its code of practice was available from a central team.
- Mental Health Act 1983 documentation for the renewal of section for a patient after November 2014 was not available in the patient record.
- Staff regularly completed audits for monitoring the use of section 58 and 60 authorisation of medication and treatment requiring consent or a second opinion.

Good practice in applying the Mental Capacity Act 2005

Wards for people with learning disabilities or autism

- Individual assessments were completed under the Mental Capacity Act 2005 where staff had concerns that a patient might have impaired capacity to give consent. Decision-specific examples included patients' capacity to make decisions regarding healthy eating and daily living skills.
- However, assessment records were not consistently completed. An assessment for a patient's ability to manage finances had not taken place. This was despite reference in their care plan as being required. Another patient had assessments for decision-making completed in 2014 showing they had capacity to make decisions.

Are wards for people with learning disabilities or autism caring?

Kindness, dignity, respect and support

- House rules for treating each other respectfully were on communal display at the location for patients and staff reference.
- We saw examples of positive staff and patient interaction and individual support. Most staff treated patients with kindness and respect.
- Patients said there were staff they liked and who gave them support.
- Two staff members reported that staff did not have the skills to interact with patients. One patient told us staff could be abrupt and shout at them. We observed occasions of staff abruptness and limited interaction with patients. We raised this with the manager who said they would take immediate action to address the concerns.
- Three patients told us that the environment could be noisy, with shouting and banging at times. However, we did not find this during our inspection.

The involvement of people in the care they receive

- Daily morning meetings with staff and patients took place to review timetables and activities for the day.
- Care plans did not capture how patients had been involved in the development of them.
- One patient's records held an 'aspirational pathway' document with the patient's views for their future from another provider's hospital.
- One patient told us they were not sure what their treatment plans were for their mental health or physical health needs.
- Two patients told us they did not always have feedback after restraint had taken place; were not sure why it had taken place and did not like it. Staff records did not detail if incidents were reviewed with patients afterwards.
- Staff supported patients to keep contact with their family and friends.
- Patients could contact independent advocates as required.

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

Access and discharge

- There were five patient admissions and four discharges in the last year. The provider said there were no delayed patient discharges and two patients had identified placements to move to.
- Two staff said they were not involved in pre admission assessments and had concerns about the appropriateness of some patient's placements. Three staff said the criteria for admission had changed and patients with more complex/challenging needs were admitted and incidents had increased. An example was given that this had posed difficulties as not all patients got along with each other. The provider confirmed that one patient's risks had increased and they required a higher level of care and they were transferred to another placement after our visit.
- Patients were from various parts of the United Kingdom due to placements not being available in their home area to meet their needs. We saw that reviews took place with commissioners to consider if the placement was still appropriate for the patient such as care and treatment reviews with NHS England. Patients had identified care pathways. One patient told us they had moved to the hospital as part of moving towards supported living.

The facilities promote recovery, comfort, dignity and confidentiality

Wards for people with learning disabilities or autism

- The hospital had rooms where patients could relax and watch television or engage in therapeutic activities. These included a lounge and activity area, access to a garden and meeting room.
- The hospital was not a purpose built environment. Some downstairs corridors were narrow, which meant that staff could not walk down them if restraining patients and wanted to take them to their rooms for their dignity and privacy. Instead, staff and patients had to walk through the garden to enter bedroom patio doors. A fire extinguisher was situated outside one downstairs bedroom door so when opened it blocked the corridor.
- Patients personalised their rooms. One patient's room had no curtains and their privacy was affected as people in the garden could see into their room. Staff said it was because they were being washed and they would ensure they were replaced.
- Patients told us they had privacy for telephone calls using a cordless telephone, as the patients' telephone was broken. They had lockable bedside cabinet drawers for valuables.
- Patients told us that snacks and drinks were available with support when they wanted.
- Patients gave mixed feedback regarding activities taking place, with some satisfied with the range amount and frequency and others not. One patient said they went to college to study maths. One patient told us they had voluntary work. Community meeting minutes in June 2015 detailed that patients wanted more activities. We saw from patient records that some group outings had taken place. Individualised patient activity plans were available but during our visit these did not correspond with activities observed. A member of staff said that these were affected due to lack of consistent staffing. The provider had a minibus and staff told us there was no current driver available, which staff said had affected group trips out. The provider was looking for a replacement driver.

Meeting the needs of all people who use the service

- Easy read pictorial care plans and fire notices were available for patients who had difficulties reading and writing.
- The provider had systems for accessing interpreters if required for patients.
- Staff provided sensory tactile, sound and light objects for patient's activities and stimulation.
- Staff records held limited information about patients' diverse needs. One patient said staff had not offered them any support for religious/spiritual needs and there was limited information in their care plan for this.
- Patients prepared their own meals with staff support, subject to risk assessment. During our visit, there was a patient who had diabetes. Records showed that staff were monitoring patients' dietary intake but record gaps showed this was not consistent. NHS guidance on healthy eating was in the kitchen for staff and patients' reference. However, recent menus did not detail how healthy eating or any dietetic advice was promoted and if patients could make meal choices. Nor was there any information if patients had preferred diets for religious, spiritual or cultural needs.

Listening to and learning from concerns and complaints

- Weekly community meetings minutes held limited detail and records did not always capture the provider's actions and timeframes for responding and resolving issues.
- Patients knew how to make complaints and staff told us they regularly did so. We found one letter written by a patient with concerns and no apparent response from staff. We asked the provider for complaints details for the last six months and we received details from 2013 and none since. We requested the latest patient survey results and the provider informed us that none of the present patients had taken part in a survey and a survey was due. Therefore, we could not be assured that the provider was taking action to respond to patients' concerns.

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

Good governance

- Management and oversight of the quality of the service was not effective. For example, there were gaps in records for risk assessments, safeguarding and incident reporting. Staff actions taken in response to incidents and concerns raised were not always documented. Audits related to health and safety were not routinely reviewed by the provider to ensure service improvement actions were completed. There were no documented actions by the provider that they were aware of the risks

to the service and were taking to address these issues other than a new manager was in post. Therefore, we were not assured that the provider was taking action to reduce risks relating to the health, safety and welfare of patients and others.

- Information and management records were not easily accessible for the covering manager and the nurse in charge to show us how the service was being assessed and monitored. For example, we asked for staff training records during our visit and the manager would not provide this during or after the inspection. Not all staffing rotas were available. Staff feedback indicated this was a records storage issue.
- Mechanisms for patients, staff and others to give feedback and for the provider to gauge the performance of the service were not consistent and did not fully detail actions taken or completed.

Leadership, morale and staff engagement

- There was a lack of consistent leadership. There had been three managers since May 2015 and there was no registered manager. There had been significant changes to the core staffing in the last year. Staff told us they had not had formal feedback from senior managers regarding the last manager leaving but instead had informal feedback from their peers. This had affected staff morale. Some staff told us they enjoyed their work and felt supported and others not. A new manager from another hospital had just started working there part time. A regional director had oversight of the hospital and others in the area, and had taken some actions to ensure management cover arrangements.
- Four staff said staff communication was affected in the team, for example, they did not have information for their daily roles or feedback from incidents. A patient was admitted to the hospital during our visit and staff had not prepared their bedroom for them. Staff told us that some staff knew about the admission a week before but this had not been communicated to them. Three staff raised concerns about incident reporting and lack of robust investigation and feedback.
- Formal staff team meetings had not been taking place monthly as per the provider's standard. Staff meeting minutes available did not fully capture actions taken or completed following staff concerns.
- Staff were not receiving adequate support. Staff monthly supervision and annual appraisal were on average 50% compliant in the last six months that was below the provider's target. Training data was not easily accessible by the covering manager for review to ensure staff compliance. This posed a risk that staff did not have the competence, skills and experience to provide safe care and treatment to patients.
- Staff were aware of whistleblowing processes and information was available them to refer to.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure a safe and clean environment.
- The provider must ensure staff receive an induction, monthly supervision and annual appraisals.
- The provider must ensure that all staff receive mandatory training.
- The provider must ensure all risk assessment and care planning systems are updated to keep patients and others safe.
- The provider must ensure robust governance systems are in place.
- The provider must ensure adequate staffing to meet the needs of patients at all times.

Action the provider SHOULD take to improve

- The provider should ensure patients privacy and dignity at all times.
- The provider should review their complaints procedures to ensure patients receive a response to concerns raised.
- The provider should ensure that patients' physical health is checked and monitored following rapid tranquilisation.

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 17 HSCA (RA) Regulations 2014 Good governance **The provider must ensure robust governance systems are in place.** Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. Such systems or processes must enable the registered person, in particular, to 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); 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; 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; maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity; seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; evaluate and improve their practice in respect of the processing of the information referred to. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation17(1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

The provider must ensure adequate staffing to meet the needs of patients at all times.

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 18(1).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider must ensure a safe and clean environment.** **The provider must ensure staff receive an induction, monthly supervision and annual appraisals.** **The provider must ensure that all staff receive mandatory training.** **The provider must ensure all risk assessment and care planning systems are updated to keep patients and others safe.** Safe care and treatment Care and treatment must be provided in a safe way for service users. The things which a registered person must do to comply with that paragraph include assessing the risks to the health and safety of service users of receiving the care or treatment. Doing all that is reasonably practicable to mitigate any such risks. Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. The proper and safe management of medicines. Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 12(1)(2)(a)(b)(c)(d)(g)(h).