Fairview

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

Overall summary

We did not rate the provider during this focused inspection as we did not cover all aspects of each domain. The provider was last rated at the comprehensive inspection, published 12 June 2017, when the service was rated as 'requires improvement.'

We found the following issues that the provider needs to improve:

- The provider had not ensured that there were sufficient staff on duty for safe care and treatment of patients. There were insufficient staff on duty and staff were not always able to take breaks during their shift. Access to activities and escorted leave was limited for those patients not on enhanced observations. Although patients had access to activities at the Joy Clare centre, most patients required section 17 leave to access this facility. Patients not on 1:1 observations who required an escort could not always participate in activities at this facility when staffing levels were low. The provider was not able to provide clear, accurate and easily accessible information about staffing levels across the hospital. Information submitted did not show how staff had been moved around the hospital to cover vacant shifts, but did indicate significant shortfalls.
- Staff did not always complete enhanced observations correctly, in accordance with patient care plans and the provider's policy. This included gaps in observation recording and failure to adhere to strategies identified in positive behavioural support plans and daily routines. We observed eight occasions where staff did not follow guidance contained in the patient's care plan.
- Staff did not always engage with patients whilst on observation. We observed long periods where staff had not interacted with patients. We also observed that staff did not always respond to patient requests. We observed examples where patients asked for support and this was not forthcoming because staff said they were busy or that equipment, such as a phone or a razor, was broken. Staff interactions with patients rarely offered therapeutic engagement.
- The provider had not ensured the safety of patients. On Oak Court, two patients had accessed the roof, and climbed the security fence on a number of occasions. The provider had not put sufficient plans in place to protect patients and mitigate the risk of further incidents. The provider had further not ensured the safety of staff, patients and the public when transporting a patient on home leave.
- Although the provider had appropriately excluded some patients from admission, they had not ensured they could meet the needs of some patients they had admitted. The provider had not consistently followed the exclusion criteria contained in their admission policy prior to admitting these patients.

Summary of findings

- The provider used closed circuit television to review some incidents on Laurel Court, Oak Court and Redwood Court. However, closed circuit television was not available across all wards and, where available, did not cover all communal areas. We were concerned that the confidentiality of patients was not protected.
- There was little evidence of patient involvement in care planning. Seven carers also said that the hospital did not communicate effectively with them concerning their relative.
- The provider had not ensured that all mental capacity assessments had been followed up with best interest decision meetings, where appropriate.
- Ongoing monitoring and management of physical health issues was not consistently maintained or recorded.

However we found the following areas of good practice:

- Staff completed physical interventions for patients, when required, appropriately and in accordance with taught techniques and the provider's policy.
- Staff knew what incidents to report and reported them appropriately.
- Staff participated in regular multi-disciplinary meetings and effective discharge planning meetings for patients.
- The provider addressed staff performance issues and took action when appropriate.
- We observed some positive interactions with patients.
- Patients had access to advocacy services.
- The provider had successfully discharged 42 patients over a 12 month period of which 76% were transferred to less restrictive placements.
- The provider had developed effective systems to ensure that safeguarding concerns were reported to the police, local authority and Care Quality Commission.
- The provider had ensured that new staff received a two week period of induction prior to working on the wards.

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Background to Fairview

Fairview Hospital is an independent hospital providing specialist services for adults with learning disabilities and/or autistic spectrum disorder who may have additional complex mental health problems and may be detained under the Mental Health Act 1983. The provider for this location is CAS Learning Disabilities Limited and the corporate provider is CAS Behavioural Healthcare Limited.

The hospital can accommodate up to 63 people. There are seven single-sex residential wards, providing assessment, treatment and rehabilitation:

- Oak Court has 12 locked rehabilitation beds for men
- Larch Court has four beds for men with autistic spectrum disorder and/or challenging behaviour
- Laurel Court has 11 rehabilitation beds for men with autistic spectrum disorder
- Redwood Court has nine beds for men with autistic spectrum disorder
- Elm Court has ten beds, for men
- Sycamore Court has six rehabilitation beds for men
- Cherry Court has 11 locked rehabilitation beds for women
- Joy Clare activity centre.

This location is registered with the Care Quality Commission to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury.

Shoenagh Mackay is registered with the Care Quality Commission as the registered manager. Simon Belfield is the identified controlled drugs accountable officer.

The Care Quality Commission previously carried out a comprehensive inspection of this location from the 21st to 27th February 2017. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for regulation 12, safe care and treatment. The provider sent the CQC their action plans to address these.

The Care Quality Commission also carried out a focused inspection of this location on the 7th July 2017. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for:

- Regulation 10, dignity and respect
- Regulation 11, need for consent
- Regulation 12, safe care and treatment and
- Regulation 15, safety and suitability of premises.

Our inspection team

The team that inspected the service comprised three CQC inspectors, two inspection managers and six specialist advisors, including nurses, a psychologist and a social worker.

Why we carried out this inspection

We carried out a focused inspection of this location in response to a number of concerns identified by the Care Quality Commission and outside agencies in relation to the safe care and treatment of patients.

Summary of this inspection

How we carried out this inspection

We carried out a series of unannounced visits to the hospital. In order to review the quality of care and treatment delivered to patients the inspection team visited the hospital on six separate occasions and included visits during the days, evening, nights and weekend. These visits took place on:

- 29 November 2017 – day visit
- 4 December 2017 – day and evening visit
- 15 December 2017 – day visit
- 18 December 2017 – day and night visit
- 19 December 2017 – day visit
- 7 January 2018 – weekend visit

Before the inspections, we reviewed information that we held about this service.

During the inspection, the team focused on reviewing the safe delivery of care to patients. The team completed 25 hours of detailed observations, including partial time sampling observations (this method of recording observations measures behaviour that occurs, or not, in any part of the five minute recording intervals). We also observed interactions using the short observational framework for inspection (SOFI is a tool developed with the University of Bradford's School of Dementia Studies and used by our inspectors to capture the experiences of people who use services who may not be able to express this for themselves. The tool records the quality of engagement between staff and patients and is appropriate for people with learning disabilities).

The team reviewed live and historical footage captured on closed circuit television, where this was available, and made comparisons to incident reporting documentation. We reviewed duty rotas to form a judgement for safe staffing levels across the hospital.

During the inspection visit, the inspection team:

- visited all wards at the hospital and looked at the quality of the ward environment;
- spoke with five patients who were using the service
- spoke with 11 carers
- spoke with the registered manager and deputy manager;
- spoke with the advocate
- spoke with 38 other staff members; including nurses, psychologist and healthcare assistants
- looked at 13 care and treatment records for patients; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- We spoke with five patients. They told us that some staff were caring and treated them with kindness and respect. However, one patient told us they had complained about the attitude of night staff, but had received no response. Two patients told us that staff were not well supported to manage aggressive and challenging patients.
- We spoke with 11 carers. All said that most of the staff were friendly, caring and polite and treated them with respect. Seven carers stated that they did not receive regular communication from the hospital, with three stating that when they phoned the hospital, their call was often unanswered and they could not leave a message. They told us they had to initiate contact in order to receive an update on their relative's care.
- Three carers said that they had great difficulty phoning the provider and another said they were not informed about changes to the staff team.
- Six carers said they did not feel that they were involved in care planning and were given limited information about how and what their relative was doing. However, four carers commented that they had been involved in their relative's care and that communication with the hospital was good.
- Carers had been invited to care programme approach meetings and care and treatment reviews.

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?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the provider needs to improve:

- The provider had not ensured the safety of patients on Oak Court. Two patients had accessed the roof on a number of occasions and had managed to climb over the fence to exit the building. The provider had not put sufficient plans in place to protect patients and mitigate the risk of further incidents.
- The provider had not ensured that there were sufficient staff on duty for safe care and treatment of patients.
- The provider had not ensured there were sufficient staff on duty to complete enhanced observations in accordance with the provider's policy.
- Staff did not always complete enhanced observations correctly, in accordance with patient care plans. This included gaps in observation recording.
- There was no formal system in place for staff to get a break during their shift.
- The provider had not ensured the safety of staff, patients or the general public when transporting a patient on home leave.
- Ward environments were damaged and had not been well maintained.
- The provider used closed circuit television to review some incidents on Laurel Court, Oak Court and Redwood Court. However, closed circuit television was not available across all wards and, where available, did not cover all communal areas. We were concerned that the confidentiality of patients was not protected.

However we found the following areas of good practice:

- Staff completed physical interventions for patients, when required, appropriately and in accordance with taught techniques and the provider's policy.
- Staff knew what incidents to report and reported them appropriately.
- The provider had set up effective systems in relation to reporting safeguarding concerns.

Are services effective?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the provider needs to improve:

Summary of this inspection

- Staff did not always adhere to strategies identified in positive behavioural support plans and daily routines. We observed eight occasions where staff did not follow guidance contained in the patient's care plan.
- Ongoing monitoring and management of physical health issues was not consistently maintained or recorded.

However we found the following areas of good practice:

- Staff participated in regular multi-disciplinary meetings and held effective discharge planning meetings for patients.
- The provider addressed staff performance issues and took action when appropriate.

Are services caring?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the provider needs to improve:

- Staff did not always respond to patient requests. We observed examples where patients asked for support and this was not forthcoming because staff said they were busy or equipment, such as a phone or a razor, was broken.
- Staff did not always engage with patients whilst on enhanced observations. We observed long periods where staff had not interacted with patients. Although we observed some positive interaction with patients, interactions with patients rarely offered therapeutic engagement.
- There was little evidence of patient involvement in care planning.
- Five carers said that the hospital did not communicate effectively with them concerning their relative.

However we found the following areas of good practice:

- Patients had access to advocacy services.

Are services responsive?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the provider needs to improve:

- Although the provider had appropriately excluded some patients from admission, they had not ensured they could meet the needs of some patients they had admitted. The provider had not consistently followed the exclusion criteria contained in their admission policy prior to admitting these patients.
- Access to activities and escorted leave was limited for those patients not on enhanced levels of observations.

Summary of this inspection

However we found the following areas of good practice:

- The provider had successfully discharged 42 patients over a 12 month period. Seventy-six per cent of patients were transferred to less restrictive placements.
- Therapeutic activities were being provided at the Joy Clare centre.

Are services well-led?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the provider needs to improve:

- The provider had not ensured sufficient staff were deployed for safe care and treatment of patients. The provider was not able to provide clear, accurate and easily accessible information about staffing levels across the hospital.
- The provider did not ensure that staff completed enhanced observations safely and in accordance with individual care plans or the provider's policy.
- The provider had not ensured there were sufficient staff on duty to enable staff to take breaks.
- The provider had not ensured that all mental capacity assessments had been followed up with best interest decision meetings, where appropriate.

However we found the following areas of good practice:

- The provider had developed effective systems to ensure that safeguarding concerns were reported to the police, local authority and Care Quality Commission.
- The provider had ensured that new staff received a two week period of induction prior to working on the wards.

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

- Patients were accommodated in single sex wards. Therefore, the provider was compliant with the Department of Health's guidance on the provision of single sex accommodation.
- The provider had not ensured that all repairs were completed in a timely manner. The ward environments for Cherry Court, Elm Court, Larch Court, Laurel Court, Oak Court and Redwood Court had not been well maintained. For example, on Redwood Court, a patient had broken some of the lights approximately three weeks previously and this was still awaiting repair. On Larch Court, an observation window in one of the bedrooms was broken. A repair had been requested two days previously but had not been completed. There was a crack in the wall in one of the patient's bathrooms on Cherry Court which had not been repaired. Some of the ward areas were dirty. On Cherry Court, the annex smelt of urine and on Oak Court there were discarded cigarette ends across the garden area and many had been trodden into the ward.
- The provider used closed circuit television to review some incidents on Laurel Court, Oak Court and Redwood Court. However, closed circuit television was not available across all wards and, where available, did not cover all communal areas. We were concerned that the confidentiality of patients was not protected as monitors were viewed in the nursing offices. For example we observed a visitor in the nursing office on Laurel ward within sight of the television monitor. The closed circuit television on Redwood Ward displayed an incorrect time. We raised this with the provider and this was corrected. The provider told us there were plans to update the system to cover all communal areas. However, we were not given a timescale for this work.

Safe staffing

- The provider had not ensured there were sufficient staff on duty to complete patient observations in accordance with the provider's policy. The provider's policy stated that staff undertaking enhanced observation within eyesight or at arm's length should do so for no longer than one hour, followed by a break. This was in recognition of the potential difficulty in maintaining concentration for more than this time. The manager and registered nurses were not able to recall the terms of their own policy and were not acting within it. Staff completed a printed observation allocation record, which had been divided into 2 hour observation periods. This document did not, therefore, reflect the terms of the provider's policy.
- On Larch Court, seven out of eight support workers were on enhanced observations for the whole of their 12 hour shift. On Elm Court and Oak Court, all support workers were engaged in enhanced observations for the whole of their shift. On Cherry Court, we saw examples of staff working for 10 and 12 hours of continuous observation and on Redwood Court we saw workers on observations for 10 hours out of a shift of 12.5 hours and six hours of continuous observations. This meant that workers undertaking observations were unable to take a break from observations in line with national institute for health and care excellence guidance (NG10) and the provider's policy. This was a risk to both staff and patients.
- Patients on enhanced observations accessed section 17 leave where appropriate, as they had staff available to escort them. However, patients who were not on enhanced observations had to rely on the availability of

staff to facilitate leave when an escort was required. Records showed that there were very few occasions when staff were not allocated to patients on enhanced levels of observations. Therefore, we were not assured that the provider had sufficient staffing to ensure all patients had access to section 17 leave, as prescribed.

- There was no formal system in place for staff to get a break during their shift of 12.5 hours. Staff were supported for short periods of time to take breaks to eat or drink. However, on Laurel Court, where there were fewer observations, staff were able to take breaks.
- The provider had not ensured the safety of staff and patients when transporting a patient. An internal investigation reported that a patient had been escorted a considerable distance to facilitate home leave, by staff who had worked the previous night-shift and were not rested. This meant that the patient, escorting staff and the public were put at risk.
- The provider used bank and agency staff to cover vacant shifts. The provider told us they had, until recently, refrained from booking agency staff to cover support worker vacancies. However, during our inspection the provider had recommenced booking agency staff to ensure safer staffing levels.

Assessing and managing risk to patients and staff

- The provider had left a significant number of shifts unfilled. Data given to us by the provider showed that during December 2017, there was a shortfall across the hospital of 840.5 support worker hours in one week, which equates to 67.2 shifts. The following week this had reduced to 244.5 hours or 20 shifts. Eighteen staff members told us staffing shortages had a significant impact on the care they were able to offer to patients.
- We visited the site on one occasion to observe staffing management on a night shift. We saw day staff were unable to go off duty until staffing shortages had been addressed. Staff told us this was a relatively regular occurrence. However, we observed that staff supported each other well during this process.
- The provider did not employ a night co-ordinator on site to oversee staffing concerns or support the wards during incidents. Staff told us they found it challenging to support other wards with the staffing available.
- We reviewed incident reports and found staff had reported concerns related to short staffing on night shifts on a number of occasions. On Oak Court, we saw seven incident forms, two relating to the same shift, reporting staffing deficits over a two month period. There were insufficient registered nurses on duty in four of these reports and insufficient support staff, given the numbers of observations required to maintain patient safety.
- Staff completed incident forms to highlight staff shortages on Laurel Court. Rotas confirmed there was short staffing on Laurel Court during November and December. We did not see evidence that staff had received a response to these concerns. Another incident form in relation to Cherry Court stated that on one night, there was no registered nurse on duty after 9.30pm. We were not assured, therefore, that sufficient staffing was always available to ensure safe care and treatment for patients, or that the provider was responding to the concerns raised by staff.
- The provider had not ensured the safety of patients on Oak Court. Patients had been able to access the roof of the building and had also exited the site by climbing over the unit fencing. During our inspection, on 29 November 2017, we observed a patient had climbed onto the fence surrounding the garden area. Staff did not respond quickly to maintain the safety of the patient. Records we reviewed showed that two patients had climbed the security fence or accessed the roof on eleven previous occasions since 8 August 2017 and on two occasions police assistance was required to manage the situation safely. However, the provider subsequently told us that there had been twelve separate incidents since June 2017. The provider had not put plans in place to mitigate the risk of further incidents. Staff did not update the patient's risk assessment until after the incident on the 29 November 2017. We raised this urgently with the provider who told us they would put a plan in place to mitigate this risk. However, there was a further incident of a patient scaling the roof of Oak Court in the evening of the same day. The provider had not put adequate or effective management plans in place to protect these patients from the risk of significant harm.

- Staff utilised physical intervention techniques in line with their training. All staff we spoke with said they had completed training in physical interventions. We observed physical interventions through historical closed circuit television footage, live footage and direct observations. We also looked at a number of incident forms where restraint had been used and watched

footage where this was available. Physical interventions were applied for minimum periods, were proportionate to the immediate risk to patients and staff, and used recognised techniques.

- We observed some staff behaving in an intimidating manner towards a patient. We viewed some historical closed circuit television footage on Laurel Court, linked to incident reports, which showed staff management of a patient displaying challenging behaviour towards the staff in attendance and fellow patients. Staff managed this patient by pointing and gesturing them to their room. The footage showed this had a negative effect on the behaviour of the patient. There were two incidents where staff appeared to make inappropriate physical contact with the patient. This was immediately raised with the provider who took immediate action to safeguard the patient.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and reported them appropriately. However, we found one example where the closed circuit television footage viewed was not in accordance with the account given in the incident form.

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

Assessment of needs and planning of care

- We looked at 13 care records across all wards in the hospital. Staff completed individualised positive behavioural support plans for patients, although this was missing in one of the records we viewed. Overall, these plans were of good quality. They contained a number of proactive and reactive strategies to a variety of known triggers and early warning signs in relation to patients' behaviour and presentation.
- Staff on the wards told us positive behavioural support plans were completed by the psychologist and behavioural therapist in response to incident forms, antecedent, behaviour and consequence (ABC) documentation and patient records. Psychologists also attended some handovers to provide additional input to staff. However, staff told us they did not always have the time to read these plans or ensure they kept themselves updated.Some plans that had been updated were not revised even when a patient moved from one ward to another. We also saw that staff did not consistently follow the positive behavioural support plan. We observed eight occasions where strategies identified in the support plans and daily routines were not followed. We were not, therefore, assured that staff were routinely able to deliver care to patients in accordance with their individualised positive behavioural support plans.
- Staff completed patient observation records. However, we found that in some of these records little or no comment was made about what a patient had been doing, and on five occasions, entries had not been completed. We saw no evidence in these records of engagement or interaction with patients.

Skilled staff to deliver care

- The provider employed psychiatrists, psychologists, nurses, support workers, a positive behavioural support lead, occupational therapists, activity co-ordinators and a speech and language therapist to provide care and treatment for patients. The provider was introducing a practice nurse to address physical health monitoring. At the time of the inspection the practice nurse had been appointed but had not started.
- Staff received a two week induction prior to working on the wards. This included positive behavioural support, safeguarding, introduction to autism, reducing restrictive practices and the management of actual and potential aggression. Training was a mixture of online learning and face to face sessions.
- The provider was requested to supply detail of specialist training delivered to staff. No information was received that demonstrated the numbers of staff who had received specialist training or the subjects covered.
- The provider addressed staff performance through supervision and through their disciplinary process. We saw evidence that when the provider became of aware of performance issues they took appropriate action.

Multidisciplinary and inter-agency team work

- Staff participated in regular multi-disciplinary meetings for patients. We observed an effective discharge planning meeting. Appropriate reports were presented which were detailed and the subsequent discussion was positive, clear and relevant.
- The provider held handovers at the beginning of each shift, where each patient's daily activities and details

were handed over to the oncoming shift. On Cherry Court this included a discussion about patient risks and observation levels. However, on Laurel Court, the handover did not discuss observation levels.
- The provider had set up effective systems in relation to reporting safeguarding concerns to the police, local authority and the Care Quality Commission. The provider had developed good relationships with the local safeguarding team and commissioning teams.

Good practice in applying the Mental Capacity Act

- Mental capacity assessments were completed for patients. However, we saw one record concerning a patient who had refused ongoing physical health checks. Staff had completed a mental capacity assessment, dated six months prior to the inspection. They recorded that the patient lacked capacity to manage their physical illness. It was recorded that this put the patient at significant risk and that a best interest meeting should take place as soon as possible. However, staff did not record that a best interest meeting or decision had taken place. The provider had not ensured they followed best practice for this patient.

Are wards for people with learning disabilities or autism caring?

Kindness, dignity, respect and support

- Staff did not always respond to patient requests. We observed examples where patients asked for support and this was not forthcoming because staff said they were busy or that equipment, such as a phone or a razor, was broken.
- Staff did not always complete enhanced patient observations in line with patient care plans or the provider's policy. During the course of the inspection, we completed over 25 hours of observations across the hospital. We also viewed closed circuit television footage where possible to review incidents that had been reported. We saw that observations were not always completed correctly. On Redwood Court we saw that staff on 2:1 observations could not see the patient as the door was only partially propped open. On two occasions, staff left their post, leaving only one staff member for a patient assessed as requiring 2:1 observations at all times. On Cherry Court we observed that staff were not supporting a patient in accordance with the written care plan, which had a significant impact on the patient and other patients on the ward.
- Staff did not always engage therapeutically with patients whilst completing enhanced observations. We saw examples where staff did not interact with patients for long periods. We observed two staff completing enhanced observation for a patient on Redwood Court who were engaged in conversation with each other and did not check on the patient over a 30 minute period. We also saw examples of staff sitting with feet up against the wall, blocking the corridor, using their mobile phones and reading a newspaper during enhanced observations. Staff interaction with patients was minimal and was mostly in response to patients trying to interact with staff. We observed little therapeutic engagement during observations.
- On Elm Court we saw two staff observing a patient who was in bed. There was little interaction with the patient. When this did take place, the patient initiated this. We saw a period of over 25 minutes where there was no interaction of any kind. We completed 45 minutes of observations on Elm Ward using SOFI (SOFI is a tool developed with the University of Bradford's School of Dementia Studies and used by our inspectors to capture the experiences of people who use services who may not be able to express this for themselves. The tool records the quality of engagement between staff and patients and is appropriate for people with learning disabilities). We observed a mixture of positive and negative engagement with patients during this time.
- Staff on Redwood Court and Laurel Court did not routinely engage with patients in a positive manner. During a 90 minute observation on Redwood Court, only 35% of the interaction was positive, using partial time sampling. This method of recording observations measures behaviour that occurs, or not, in any part of the five minute recording intervals. A further 80 minute observation on Redwood Court showed that only 12.5% of interactions were positive. For example, we observed a patient asking to make a phone call was told the phone was broken. He asked several times if he could make a call, stating it was an emergency, before finally giving up. A similar observation over 85 minutes on Laurel Court showed that only 23.5% of interactions

were positive. We saw a patient calling for a member of staff 10 times before they got a response. Staff told patients who went to the ward office that they were busy.
- On Elm Court, a member of staff supporting a complex patient was heard to make negative comments about the benefit of escorting the patient on a period of leave.
- On Cherry Court we witnessed a 45 minute period where 100% of the interactions were positive and all patients were included in the conversation. We saw some positive staff interactions with a patient on Elm Court, using a variety of activities the patient enjoyed. We also saw a number of other caring interactions between staff and patients. We saw staff knocking on patient's doors, and staff talking to patients in a caring and respectful manner.

The involvement of people in the care they receive

- Staff did not always involve carers in patient's care planning. We spoke with 11 carers. Six carers did not feel that they were involved in care planning and were given limited information about how and what their relative was doing. However, four carers commented that they had been involved in their relative's care and that communication with the hospital was good. Carers had been invited to care programme approach meetings and care and treatment reviews.
- There was limited evidence of patient involvement in care plans. Patients did not routinely sign their care plans and when patients were unable to understand or sign their support plans.
- Patients had regular access to advocacy. The provider initiated access to advocacy when safeguarding concerns were recorded and reported to the local safeguarding team.

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

(for example, to feedback?)

Access and discharge

- The provider had admitted patients whose presentation and risk factors sat outside of their inclusion criteria. The provider had a policy which included criteria for admission of patients to the service. The policy also included detail of presenting risk factors, which, if identified during the assessment process, would determine the patient was not suitable for admission to the hospital. We reviewed referral documentation for three patients and found evidence of risk factors that suggested the patient was not suitable for this service. For example, we saw that patients had been admitted who required greater than 1:1 observations on admission. Information from referrers had identified high levels of challenging behaviour, a history of violence towards staff and a requirement for access to seclusion facilities. We also saw that a patient with a diagnosis of autistic spectrum disorder was admitted to a ward that did not accept referrals for patients with this diagnosis. The provider tried to engage commissioners to move clients who they subsequently felt were not well placed at the hospital. However, significant delays resulted before patients were transferred to more suitable placements.

- The provider had successfully discharged 42 patients in the previous 12 months. Of these patients, 76% had been discharged to less secure placements such as residential or supported living settings.
- The provider had appropriately excluded a number of patients from admission. This occurred following assessment that indicated the patients' needs could not be safely met at this hospital.

The facilities promote recovery, comfort, dignity & confidentiality

- Patients did not always have access to activities and escorted leave. Due to staffing shortfalls identified across all wards in the hospital, access to activities and escorted leave was limited for those patients not on enhanced levels of observation.
- We observed that therapeutic activities at the Joy Clare centre, outside the hospital grounds was beneficial to and enjoyed by patients. However, patients who required an escort to attend this facility could only do so if there were sufficient staff on the wards to facilitate this. We did not observe many activities taking place on the wards for those unable to attend the Joy Clare centre.
- There were limited quiet areas on the wards for patients to meet with their visitors The provider had some rooms off the wards and a visitor's centre where this could take place.

Wards for people with learning disabilities or autism

- The wards did not have appropriate quiet areas for staff to nurse patients who were distressed, agitated or presenting with high risks. We saw staff managing high levels of risk to patients and staff within corridor areas. This had resulted in other patients being unable to access communal facilities, or participate in ward activities.

Meeting the needs of all people who use the service

- The provider supported patients from a variety of ethnic backgrounds. However, we observed notes which stated that a patient had to be reminded several times to speak in English rather than their native tongue.

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

Good governance

- The provider had not ensured that all patients were admitted in accordance with the admission criteria for the service. Evidence showed that three patients had been admitted whose presentation and risk profile met the exclusion criteria in the provider's policy. This had resulted in high acuity levels on the wards and increased risk to both patients and staff.
- The provider was not able to provide clear, accurate and easily accessible information about staffing levels across the hospital. Managers said that they were aware of staffing levels and shortfalls but were not able to demonstrate safe staffing levels retrospectively. Where data was provided, it showed significant staffing shortfalls, particularly on Cherry Court, Oak Court, Laurel Court and Larch Court.
- The provider did not ensure that enhanced observations were carried out safely and in accordance with policy. We reviewed enhanced observation allocation sheets across all wards and found staff completing many hours of continuous observations, without taking breaks. All wards in the hospital used printed observation sheets divided into two hour periods to record staff observations of patients. Managers and registered nurses were not able to recall the terms of their own policy, which stated that staff undertaking enhanced observations should do so for no longer than an hour, followed by a break, and were not acting within it. There was a risk that staff would become tired, lose concentration and not provide therapeutic care for these patients.
- The provider had not ensured that all staff were able to take a break. Due to the pressure to complete close observations and the lack of additional staff to support this, staff were not routinely able to access a break during their shift.
- Staff we spoke with said they had received a two week period of induction prior to working on the wards. This included an introduction to learning disability and autism, positive behavioural support, challenging behaviour and risk management. Senior managers told us staff had access to specialist training in, phlebotomy, self-harm, suicide and risk, epilepsy, personality disorder training, Tourette's syndrome, Prada-Willi, investigation training and absence management training. However, we did not receive a response to our request for data on staff compliance with this training. Positive behavioural support training was delivered to new staff as part of their induction but had not been extended to all staff. We were not, therefore, assured that staff had access to relevant training to support them in their roles.
- The provider had developed effective systems to ensure that safeguarding concerns were reported to the police, local authority and Care Quality Commission.

Leadership, morale and staff engagement

- Staff we spoke with were confident to raise concerns without fear of victimisation. We interviewed 35 nurses and support workers and 33 of these stated that they would report poor practice and knew how and to whom they should report. We saw evidence of staff using the provider's whistleblowing policy to report poor practice. Evidence showed the provider responded appropriately when concerns were raised.
- Morale at the hospital was mixed. Some staff said they received high levels of job satisfaction, whilst others were frustrated at the lack of opportunities for promotion or development. A total of 18 staff expressed concerns about the understaffing on wards in relation to patient safety and rehabilitation. Staff told us they often did not get a break and staff retention was an issue.

Wards for people with learning disabilities or autism

- We saw evidence of teamwork and support on the wards. However, there was not a shared vision about completing, implementing and updating positive behavioural support plans across the hospital.
- Senior staff told us the provider had plans to reduce the number of beds at the hospital but provide the same staffing complement as they do currently. However, despite requests, we have not had confirmation of these plans or how the provider will achieve these reductions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff are aware of, and follow positive behavioural support plans for patients.
- The provider must ensure all patients have access to therapeutic activities in accordance with their care plans.
- The provider must ensure that observations are completed in accordance with care plans and the provider's policy.
- The provider must ensure that patients cannot access the roof or exit over the security fence on Oak Court.
- The provider must ensure that all patients being escorted on home leave are transported in a safe manner.
- The provider must ensure that staff protect patients from physical, emotional and psychological harm.
- The provider must ensure sufficient staff are deployed to ensure safe care and treatment for patients.
- The provider must ensure that patients referred to the hospital are assessed and admitted in accordance with its referral and exclusion criteria.
- The provider must ensure that clear, accurate information about staffing levels across the hospital is well maintained and accessible.
- The provider must ensure that systems are in place, so they are assured they can deploy staff with suitable skills and knowledge.

Action the provider SHOULD take to improve

- The provider should ensure that it communicates effectively with carers and provides regular updates where this is appropriate.
- The provider should ensure that all staff are able to take a break during their shift.
- The provider should ensure that all mental capacity assessments are followed up with best interest decision meetings where appropriate.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider had not ensured that staff followed positive behavioural support plans. • The provider had not ensured all patients had access to therapeutic activities. • The provider had not ensured that observations had been completed in line with care plans or the provider's policy. **This was a breach of regulation 9**

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 had not ensured that all patients being escorted on home leave were transported in a safe manner. **This was a breach of Regulation 12**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider had not ensured that all staff protected patients from physical, emotional and psychological harm. **This was a breach of regulation 13**

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 had not ensured that systems were in place to ensure that they could deploy staff with suitable skills and knowledge. **This was a breach of regulation 17**

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 had not protected patients from the risk of significant harm of falls from height by preventing patients from climbing the fence and gaining access to the roof on Oak Court. **This was a breach of regulation 12** **We issued a Warning Notice for the breach of this regulation**

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 **Good governance** • The provider had not ensured that observations were carried out in accordance with its own policy. • The provider had not ensured that it admitted patients in accordance with its referral and exclusion criteria. • The provider had not ensured they kept clear, accurate information about staffing levels across the hospital. **This was a breach of regulation 17** **We issued a Warning Notice for the breach of this regulation**

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured that it had sufficient staff to ensure that all patients were cared for safely. **This was a breach of regulation 18** **We issued a Warning Notice for the breach of this regulation**