Lakeside

Quality Report

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

Ratings

Overall rating for this location

Are services safe?	
Are services well-led?	

Overall summary

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

- Ward environments were dirty, unkempt and poorly maintained. They were not welcoming or appealing.
- All wards had blind spots and ligature risk assessments were not robust enough to effectively mitigate risk where there were poor lines of sight.
- The providers' management of medication was poor. Clinic rooms contained out of date medication and equipment.
- Shifts were not consistently covered with a sufficient number of staff. The service had a high level of new and inexperienced staff and relied heavily on bank and agency staff. Staff turnover was high at 56%.
- Registered staff were not visible on the wards and staff were not having regular individual sessions with patients.
- Staff told us that leave and activities were cancelled due to staffing issues.
- Compliance with mandatory training was low for bank staff and low in some areas for permanent staff.
- There were gaps in patient observation records that meant we could not be assured that patients were always kept safe.
- The seclusion room did not meet the Mental Health Act Code of Practice guidance and some seclusion records were incomplete.
- There were unlawful restrictions placed on informal patients.

Summary of findings

- Staff morale was low and staff did not have confidence that senior managers would address issues and make improvements.
- Not all staff were receiving supervision in line with policy. Bank staff were not receiving regular supervision and the compliance rate for managers was low at 61%.Staff told us that supervision was not individualised and did not met their needs.
- Staff were not receiving annual appraisals.
- The clinical governance process was not robust at improving standards of care and treatment for patients.
- Staff told us that they did not receive de-brief or felt supported following incidents. The process for sharing lessons learnt was not robust.

However, we also found the following areas of good practice:

- All wards complied with Department of Health guidance on eliminating mixed sex accommodation.
- Most staff were aware of safeguarding procedures and how to report an incident should they need to.
- Staff completed risk assessments for each patient upon admission.
- Ward managers were described as supportive and approachable.
- There was an established whistle blowing process that staff used.
- We observed some positive team working at ward level.

Summary of findings

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Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Lakeside

Lakeside provides care, treatment and support for patients on the autistic spectrum, and support with mental health concerns, anxieties, or learning disabilities. The hospital has 11 units for patients who require rehabilitation. At the time of inspection, three units, Gifford 1 and Gifford 2 and Elstow 4 were closed and unoccupied due to refurbishment. Eight units were open and there were 46 patients receiving care and treatment.

- Ashwood unit provides ten beds for women. This is a locked unit for people with autism, personality disorders, challenging behaviours. The unit is split over two floors and has an upstairs quiet annex.
- Elstow 1 unit provides five beds for women. This is a locked unit, but for more stable patients stepping down from Ashwood Unit.
- Elstow 2 unit provides six beds for younger men (18-25 years). This is a locked unit.
- Elstow 3 unit provides nine beds for men. This is a locked unit.
- Elstow 5 provides eight beds for men. This is a locked unit for more stable patients stepping down from Cooper 1, Elstow 3, and Elstow 4.
- Cooper 1 unit provides seven beds for men. This is a locked male intensive care and admission unit.
- Cooper 2 unit provides seven beds for men. This is locked unit for men with a learning disability.
- Cooper 3 unit provides four beds for men. This is an intensive behaviour support unit for individuals with challenging behaviour who at the time are unable to live with others.

At the time of inspection, there was a registered manager in post.

Lakeside is registered to carry out the following regulated services:

- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the 1983 Act.

Lakeside was previously known as Milton Park Therapeutic Campus. The service changed it name in January 2018. The service registered with the CQC in 2005. The CQC has carried out seven inspections since 2010. Routine inspections were carried out in July 2011, September 2012, May 2013, and an inspection to check improvements in August 2013. The last comprehensive inspection was carried out in July and August 2015 with an overall rating of inadequate. Safe and well–led was rated as inadequate, effective and caring as good and responsive as requires improvement. This report was published in May 2016 due to challenges raised from the provider.

Action the provider must take to improve :

- The provider must ensure that action is taken to identify ligature risks and to mitigate risk where there are poor lines of sight.
- The provider must ensure that action is taken to ensure that premises are kept clean and properly maintained in line with infection control standards.
- The provider must ensure that the seclusion suites meet the requirements of the Mental Health Act code of practice.
- The provider must ensure that an effective induction is in place for agency and bank staff.
- The provider must ensure that staff receive the appropriate training and support to enable them to meet individual patient needs.
- The provider must ensure that there is sufficient, up to date, emergency equipment and fire equipment available.
- The provider must ensure that there are robust patient discharge arrangements in place and there is discharge planning for patients when planning to leave the service.
- The provider must ensure that there are sufficient, experienced, staff on duty at all times to provide care and treatment to meet patients' needs.

Summary of this inspection

- The provider must ensure that patients under 18 years of age receive age appropriate services.
- The provider must have an effective governance process, including assurance and auditing systems in place to monitor the care and treatment provided to patients, including incidents of restraint.
- The provider must seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders.

Action the provider should take to improve:

- Ensure patients can personalise their bedrooms, where this is their choice.
- Ensure private space available for patients to see their visitors on all units.
- Ensure the patients' information handbook and written information about children's visiting is updated.
- Ensure improved coordination between staff on the units and star centre staff to facilitate regular patient's activities.

A focused inspection took place in September 2016 to look at safe and well-led and was rated as required improvement. This overall rating was reviewed to requires improvement.

Action the provider must take to improve:

- The provider must ensure there is sufficient staff on the unit with experience and skills to meet the patients' needs.
- The provider must ensure that where patients' are secluded in their bedrooms then the seclusion process and policy is followed.
- The provider must ensure that seclusion rooms are fit for use and meet the requirements of the Mental Health Act Code of Practice.
- The provider must ensure that staff follow the National Institute for Health and Care Excellence guidelines for monitoring patients physical health following administration of medication.
- The provider must ensure that staff are appropriately trained in the use of resuscitation equipment.
- The provider must ensure that staff follow best practice for storage and disposing of sharps and medication.
- The provider must ensure that there are adequate staff in post to keep the units clean and well maintained and that cleaning records are up to date.

Our inspection team

The inspection team leader was Deborah Holder.

The team that inspected Lakeside consisted of an inspection manager, four CQC inspectors, a Mental Health Act reviewer and three nurse specialist professional advisors.

The team would like to thank all those who met and spoke with them during the inspection.

Why we carried out this inspection

We carried out an unannounced focused inspection of Lakeside on 27- 29 November 2017 and 12 December 2017 due to concerns raised to the CQC.

The concerns included:

- concerns regarding staffing levels
- standards of care and treatment provided to patients
- low staff morale
- lack of support by management

Summary of this inspection

How we carried out this inspection

This was a focused inspection and asked the following questions of the service:

- Is it safe?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited all eight of the wards at the hospital site and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with 42 other staff members; including doctors, nurses, support workers and managers
- spoke with one carer
- looked at 25 treatment records of patients.
- carried out a specific check of the medication management on all wards
- 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 nine patients who used the service. One patient told us that the wards were frequently dirty. Two patients told us that the bathrooms and communal areas were not cleaned regularly. Two patients told us that their leave had recently been cancelled due to staff shortages. One informal patient told us that staff did not always let them off the ward when they wished to leave.

One patient did not know how to complain and another patient did not feel that staff appropriately supported them when they wished to make a verbal complaint; they told us that when they asked to speak with staff to discuss their concerns they were given the complaint paperwork and not provided with the opportunity to discuss their issues.

One patient told us that they were happy with their care and treatment and another patient was positive about the staff on the ward. One patient told us that weekly community meetings took place on the ward and monthly patient forum meetings across the service however they never received the minutes from these meetings.

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?

Ratings are not given for this inspection

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

- Wards were dirty, unkempt and poorly maintained.
- All wards had blind spots and ligature risk assessments were not robust.
- Clinic rooms contained out of date medication and equipment.
- Most staff told us that staffing levels were inadequate, which compromised patient care and treatment.
- The service had a high level of new and inexperienced staff and relied heavily on bank and agency staff.
- Staff turnover was high at 56%.
- Staff did not observe all patients in accordance to their care plans.
- Registered staff were not visible on the wards and staff were not having regular individual sessions with patients.
- Staff told us that leave and activities were cancelled due to staffing issues.
- Compliance with mandatory training was low for bank staff and low in some areas for permanent staff.
- The seclusion room did not meet the Mental Health Act Code of Practice guidance and accurate and full records were not maintained.
- There were restrictions placed on informal patients.

However:

- The unit complied with Department of Health guidance on eliminating mixed sex accommodation.
- Staff were aware of safeguarding procedures and how to report an incident.
- Staff completed risk assessments upon admission.

Are services well-led?

Ratings are not given for this inspection

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

- Staff morale was very low. Staff lacked confidence in senior management and did not feel supported.
- Managers did not ensure that staff received mandatory training in accordance to their policy.
- Staff were not receiving supervision in line with policy. Bank staff were not receiving regular supervision.

Summary of this inspection

- Compliance rate for managers was low at 61%.Staff told us that supervision was not individualised and did not meet their needs.
- Managers did not ensure that staff received appraisals, compliance rate was low at 13%.
- Managers did not ensure that the ward environments were clean, safe and appropriately maintained.
- A clinical governance process was in place but this system was monitoring and not improving standards.
- Staff told us that they did not receive de-brief following incidents. The process for sharing lessons learnt was not robust.

However:

- Most staff told us that their immediate ward manager was supportive.
- Staff were aware of and used the whistle blowing process.
- We observed some positive team working at ward level.

Wards for people with learning disabilities or autism

Safe	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- The layout of all the buildings meant that all units had blind spots. Staff could not observe areas of the units at all times to keep patients safe. Managers told us that they mitigated this risk with nursing observations. We were not assured that the mitigation of nursing observations were sufficient to ensure adequate observation of all areas at all times. Whilst there were adequate staff on the wards to cover enhanced observations, staffing levels were not sufficient for staff to have sight of all areas of the wards. On Cooper 3 we observed that staff were not with a patient that was nursed on enhanced observations.
- The managers had installed closed circuit television (CCTV) and some observation mirrors. CCTV was not monitored so did not assist with observations. Staff would review CCTV footage as part of investigation processes and to establish events.
- Wards had up to date ligature risk assessments, managers had reviewed the assessments on 13 September 2017. These risk assessments were not robust, action to mitigate risk areas were generalised, and additional action was generally identified for high risk points only. We were not assured that staff were monitoring these areas effectively. The ligature risk assessments on Cooper 1 and Elstow 2, and Elstow 3, did not identify any additional measures for taps whilst they wait for sensors to be fitted. Taps were assessed as high risk on Cooper 1 and medium risk on Elstow 2 and 3. Cooper 3 ligature risk assessment had identified constant observation as an additional measure for many of the ligature points; we observed that patients were not always in eyesight of staff.
- The unit complied with Department of Health guidance on eliminating mixed sex accommodation, as there were separate units for male and female patients.
- There were clinic rooms on each ward. Clinic rooms were small but were clean and organised. We were not assured that effective weekly checks of stock and equipment were taking place on all wards. We found issues in five of the eight clinics.
- On Cooper 1 the clinic contained patient only medication that was not labelled. The weekly checks of emergency equipment were not always taking place and the Epipen had expired. We found out of date syringes. There was no cleaning record for physical health equipment. One of the bins for disposing of sharps had no date opened or staff signature.
- On Cooper 2 the clinic contained out of date syringes.
- On Cooper 3 weekly checks of equipment were documented however the burn kit in the first aid box was out of date.
- On Elstow 2 clinic the weekly checks of equipment were documented however items in first aid kit including; sterile wipes, gloves, plasters, bandages, and burns kit were out of date. The drug testing kits were out of date. The pulse oximeter was ticked as being present but not on the ward. We were subsequently told it had been borrowed by another ward. Sterile water used for injections was out of date.
- On Ashwood clinic the defibrillation pads were out of date; there was no medicinal disposal bin in the clinic. Known allergies for one patient had not been documented on the medication chart. The emergency response bag was not checked weekly.
- The provider told us about procedures for reporting drug errors however two registered nurses were not able to demonstrate they were aware of these.
- The service had one seclusion room, located on Cooper 1. This did not meet the Mental Health Act Code of Practice. The convex mirror installed to improve observation was damaged and line of sight was obscured. The mirror trim was sharp and broken presenting a potential risk. There was poor line of sight from the entrance door to the ensuite bathroom. The smoke detector was not securely fitted to the ceiling

and could be removed; the ceiling structure was not robust and could be reached by standing on the seclusion mattress. The heating system had been covered however this structure was not robust and could be pushed in; it had air vents that were rough and could be used for self-harm. There was carpet on the floor that was not practical and got wet when the shower was used.The seclusion area contained a clock and the two-way communication system was in working order.

- Issues were reported to the registered manager on inspection who took immediate action and decommissioned the seclusion room for repairs to be made.
- All wards were dirty, unkempt and unwelcoming and were not well maintained. We checked cleaning rotas and found significant gaps in daily recording. Ward staff were responsible for the day to day cleaning of the ward due to recruitment issues with housekeeping.
- Cooper 2 dining room had one table and four chairs for six patients. However, patients preferred to eat separately. The lounge contained heavy safety furniture and there were no curtains in place. There was an old trampoline in the garden that staff told us should be removed for safety reasons. The communal bath had no viewing panel to assist staff with observation. Staff told us that they leave the door ajar if they need to observe patients.The ceiling in the bathroom appeared damp. We noted a chair placed in front of one fire exit.
- Cooper 3 ward was bare, the provider told is that this was because patients had a tendency to damage the environment. One toilet was stained and unpleasant.
- Elstow 1 had no curtains up in the dining room; staff told us that patients kept pulling them down. There were blinds in place. There was a hole in the kitchen ceiling due to repairs taking place.
- On Elstow 2 one bedroom smelt strongly of urine and it was noted that there was obscene language over the walls. The ward was shabby and bare. Rawl plugs were exposed in some walls and paint work was scuffed. Cleanliness on the ward was basic. There was no information displayed for patients. The provider told us that they were working with specific patients regarding hygiene and that the patient group caused regular damage to the ward environment.
- On Elstow 3 bedrooms and bathrooms were dirty, and there was an unpleasant odour on the ward. Furniture in the communal area was broken.
- On Elstow 5 the lounge sofa was ripped as were chairs on the first floor. Some areas of the ward were dirty, there was an unpleasant odour in one bedroom and there were paint splatters over the floor in communal areas. The provider told us that they had ordered replacement furniture and they had been unable to remove the paint splatters.
- On Ashwood there was an offensive odour in some areas of the ward. One toilet had no toilet seat. One bedroom was very dirty as was two patients' en-suite toilets. The garden was littered with cigarettes.
- The provider had oversight of maintenance and environmental issues and monitored this but did not address issues in a timely manner. For example; damage to the seclusion mirror was reported on 9 November 2017, staff reported windows needing replacement or repair across several wards in July and September. In September staff on Elstow 1 reported issues with unlevelled flooring in the garden. All these issues were still outstanding in November 2017. Routinely, there was a four week wait for maintenance to address minor issues such as repairing lights.
- The service had a response alarm system in place. We observed that staff activated alarms when they required assistance.
- Wards had radios to help with raising assistance; we saw that these were routinely left in the office which delayed staff response. On two occasions staff left radios unattended in communal areas. On Elstow 3 a staff member had turned the radio off. On Elstow 1 we observed staff had to retrieve the radio from the office to cancel a response.
- Each ward had a pager to assist with responding to alarms, these were routinely left in the office and staff confirmed that they did not carry these.When staff failed to respond to an incident this was not always recorded on the provider's electronic system. Staff reported a reluctance to respond to alarms due to the likelihood of being injured or because it could be a false alarm. We were not assured that staff responded to an alarm as quickly as they could.

Wards for people with learning disabilities or autism

Safe staffing

- Managers told us their staffing establishment was set at one staff to every two patients. Due to the nature of the patients there was a high number of additional staff required to observe patients on enhanced observation. On one day of inspection 32 staff were required to cover enhanced observations.
- Sickness rate averaged 3% between June and November 2017. Managers were not consistently supporting staff back to work following periods of sickness. In August 2017, there were 70 outstanding return to work interviews and in September 2017, 162. In November 2017 staff took a total of 261 hours sick as a result of work related injury following physical assaults on staff by patients. The provider told us managers informally supported staff back to work.
- The service reported a high turnover of staff with 110 leavers between January 2017 and October 2017. Five of these leavers transferred to bank staff, 12 staff were dismissed and 9 were non-starters. Overall, leaver's rate was equivalent to 56% of staff.
- We examined the rotas and found that shifts were not always covered with the optimum number of staff. Between September and December 2017 133 shifts were unfilled. On some shift the managers were able to staff above there required establishment. In addition to this the planned establishment was low on a day to day basis. On some wards there were sufficient staff to cover the enhanced observations but there were no additional staff to support the remaining patients, cover for staff breaks or support activities and treatment. Staff confirmed that they did not consistently receive their breaks as if they left the ward there would be insufficient staffing to ensure that patients were safe. Cooper 2 and Cooper 3 ward shared a registered nurse at night. Overall, 16 staff told us that staffing levels were insufficient.
- The service used bank and agency staff to cover shifts. There was a high dependency on agency staff to cover planned shifts. Agency staff filled 53% of registered nurse shifts and 22% support workers shift hours between April and October 2017. We saw that some agency staff were familiar with the wards that they were working on. We observed on one ward two staff did not know how to respond to a patient's behaviour and had to ask for a third member of staff to assist. We were not assured that all staff had knowledge and understanding of patients care plans and risk issues. The provider told us that they tried to use regular agency staff whenever possible.
- The managers told us that they were able to adjust staffing levels daily, dependent upon the needs of the patients and planned activities. However, managers were not always able to fill the planned staffing establishment.
- Registered nurses were not visible on the wards or interacting with patients. In addition managers worked across two wards so were not always available to support.
- Staff did not always document if weekly individual sessions with all patients were taking place. Six staff told us they did not have time to prioritise named nurse sessions with patients over other tasks.
- We spoke with 42 members of staff, 17 staff told us that leave or activities were cancelled due to staffing issues. Two patients confirmed this. We saw evidence on some wards where leave had been cancelled or postponed due to staffing.
- Staff were carrying out physical interventions when required.
- Managers told us that there was sufficient medical cover across the service. Staff told us that doctors would respond to phone calls and emails however would not attend the ward following an incident when staff felt it would have been beneficial. In a medical emergency staff phoned for an ambulance. We observed that the service called for an ambulance during inspection for a suspected sprain, the registered nurse told us that this was the quickest way to ensure that the patients' received the necessary medical attention.
- Managers did not ensure that all staff were up to date with mandatory training. The provider's compliance target was set at 80%, which they did not achieve. Overall compliance for bank staff was 53%. It was significantly lower in some areas; fire safety 22%, infection control 48%, moving and handling 9%, safeguarding 43% , safeguarding level 2 0% and Milton Park fire safety 35%.

Wards for people with learning disabilities or autism

- Overall, compliance to mandatory training for permanent staff was 77%. This was significantly lower in some areas; fire safety 71%, infection control, 63% moving and handling 65%, first aid 63% information governance 48%, safeguarding level 2 43 % and positive behavioural support 73%.
- Safeguarding training was mandatory. A total of 81% of permanent staff and 43% of bank staff had completed this. Staff interviewed were aware of what constituted a safeguarding referral and could explain the process of reporting.
- Between August and November 2017 the service reported 23 safeguarding incidents involving 10 patients. Nine of these were on Ashwood, nine of Elstow 1, two on Elstow 5 and one on Elstow 2, Elstow 4 and Cooper 2. Five of these incidents involved patient self-harm whilst nursed on enhanced observations, three were allegations of abuse against staff. The local authority in ten incidents undertook section 42 safeguarding investigations. In August 2017 one incident of neglect against the provider was upheld which resulted in two staff dismissals.

Assessing and managing risk to patients and staff

- Between August and October 2017 there were 12 episodes of seclusion recorded across the service.
- There were 1,059 incidents of physical intervention across the service between January and November 2017. Overall, 30% of restraints occurred on Cooper 3, 19% on Ashwood and 14% on Cooper 1 ward.
- Staff managed patients under long term segregation arrangements. We found that the provider had recently updated their policy to reflect that monthly multi-disciplinary reviews of patients would take place. The Mental Health Act Code of Practice stipulates that individuals are reviewed at least weekly. At inspection there were five patients managed under this arrangement.
- We reviewed 25 care and treatment records and saw that staff routinely completed a risk assessment of patients on admission. Staff updated risk assessments however these were not always accurate or in detail. For example, two assessments had been reviewed but did not reflect the correct ward. Another assessment identified a new risk but did not include any actions to manage this risk.
- Staff used the company risk assessment tool to capture areas of risk including, historic risks.
- The service ensured that any restrictions upon patients were risk assessed. We did not identify any blanket restrictions in place at the time of inspection.
- Informal patients could not always leave at will. One patient had not been permitted to leave the ward on occasions when they wished to. The patient and staff confirmed this and we saw documentation to support this. This patient had also been restrained on numerous occasions.We were not assured that the clinical team gave sufficient consideration of the patients' legal status following incidents as outlined in the Mental Health Act Code of Practice. Two other informal patients had care plans that referred to them being placed under the Mental Health Act should they try to leave their wards.
- The provider had policies and procedures for use of observation and searching patients. Observations were not always followed in line with policy. Staff told us that at times there was insufficient staffing to ensure that observations were always completed. We found gaps in observation records on Cooper 2, Cooper 3 and Elstow 1.
- Staff told us that they used restraint as a last resort. Overall, 95% of permanent staff were trained in restraint techniques. Staff verbally de-escalated the patients and engaged with them on a one to one basis. When staff did use restraint, this was in line with taught techniques and documented. The provider had changed techniques to better meet the patient's needs however some staff told us that the taught restraint technique was not effective to manage some of the patients and did not feel it was safe or robust.
- The use of rapid tranquilisation followed National Institute for Health and Care Excellence guidance.
- At the time of inspection the seclusion room did not meet the Mental Health Act Code of Practice guidance. Since inspection the provider has made improvements to this area. Staff told us that on occasion patients were secluded in bedrooms and in a quiet room. There was a

process in place for documenting seclusion. Once staff completed the paperwork they sent it to the Mental Health Act administrator for review and filing. We reviewed six seclusion records and found them to be of varying quality.

- We were not assured that seclusion records were appropriately maintained. One record had no plan in place to support staff or the patient to exit seclusion. The seclusion paperwork was not fully completed; the patient had known physical health concerns that required stools to be monitored but this paperwork was not present. The 15 minute nursing observation form had gaps between 01.00 and 02.35. The doctor had not signed the four hourly medic reviews; the nurse had not signed the nursing review. We found that both the doctor and the nurse retrospectively signed the paperwork several days later. The gaps in nursing observations were not accounted for.
- The second record indicated that seclusion was terminated at 03.05 as the patient was asleep but then recommenced. There was no documentation or evidence to explain or support this decision and this seclusion was not recorded on new seclusion paperwork.
- Three records showed that doctors did not arrive within an hour of seclusion commencing in accordance with policy.
- The provided completed regular audits of seclusion paperwork and had a process in place to identify gaps in records.
- Safeguarding training was mandatory. Overall, 81% of permanent staff had completed this training. Most staff interviewed were aware of what constituted a safeguarding referral and could explain the process of reporting or who they could contact for support.
- Medicines were stored securely. Staff monitored the temperature of the clinic and the fridge to ensure the temperature did not affect the efficacy of medications. Between August and October 2017 there were 30 recorded medication errors. We noted that staff did not record all medication errors on the providers' electronic system.
- The service had procedures in place for any children who visited. Visits were facilitated in the cafe, which was within the hospital grounds.

Track record on safety

- There had been one reported significant incident reported over the last three months.
- Staff reported most incidents via the electronic reporting system. Managers were not closing off incident reports in a timely manner.

Reporting incidents and learning from when things go wrong

- Most staff interviewed knew what constituted an incident and could explain the reporting process in place, through verbal escalation; recording the incident electronically and also in the patients clinical notes. Staff told us that not all incidents were reported and we saw evidence of this in ward team meetings and clinical governance minutes.
- Staff did not always feel that the service were open and transparent when things went wrong. Staff felt that there was a culture of blaming staff following an incident rather than offering staff the support that they needed.
- Staff told us that they did not consistently receive feedback and learning from incidents and investigations and could not give examples. Regular effective team meetings were not taking place and information discussed within management meetings was not cascaded to staff.
- The provider had made changes to practice and improvements following incidents however we saw that changes to practice had not always been sufficient to prevent further incidents of the same type from occurring, for example self-harm.
- Staff told us that they were not always given appropriate support following a serious incident. They told us that following an incident such as a physical assault they were expected to get back to work quickly. The provider told us that there were appropriate mechanisms for de-briefs in place across the service.

Wards for people with learning disabilities or autism

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

Vision and values

- The provider had set visions and values. Some staff were aware of these but they were not robustly embedded in practice. Many staff were disillusioned with managers and the organisation.
- Regular team meetings were not taking place across the wards to support the staff to develop understanding of team objectives.
- Staff knew who immediate managers were. Some staff described them as supportive however the majority of staff spoken with felt that senior managers were not visible, supportive or took action to address concerns that they raised.

Good governance

- The service held monthly clinical governance meetings that were attended by key individuals. We reviewed the minutes from August to November 2017 and saw that the team discussed essential areas for governance oversight. The provider had qualitative information to monitor compliance however this had not led to sustained improvements.
- Managers did not ensure that all staff received mandatory training. The providers target was 80%. Overall 77% of staff had completed mandatory training. Compliance was significantly lower in some areas.
- Managers did not ensure that staff received annual appraisals. Compliance rate was very low at only 13%. Some staff told us that the appraisal processes was not individualised or meaningful and they did not value the process.
- The providers' supervision policy stipulated staff must receive supervision a minimum of six weekly. Overall 79% of staff received supervision between January and October 2017. Manager's supervision compliance was lower at 61% for the same period. Bank staff did not receive regular supervision.
- Managers did not ensure that a sufficient number of care staff of the right grade and experience covered all shifts. There was a high reliance on agency staff. Between April and October 2017 53% of registered nurse and 22% of health care assistant shifts were filled by agency. Between August and November 2017 27% off all shifts were covered by agency staff. The provider told us that they tried to use regular agency staff whenever possible. A recent recruitment process had resulted in a high number of new staff across the service.
- Staff were unable to maximise shift-time on direct care activities on all the wards. Staffing numbers permitted staff to cover enhanced observations across the wards. In addition ward based staff were supporting the cleaning of the wards.
- Clinical staff participated in a variety of audits on medication and clinic room, nutrition, infection control, health and safety and compliance to the Mental Health Act.
- Staff reported most incidents via the providers electronic report systems however managers did not always close off incidents in a timely manner.
- Safeguarding procedures were followed. Managers were not consistently adhering to best practice guidance under the Mental Health Act; seclusion paperwork was not robustly completed, there were restrictions in place for informal patients and the providers' policy for long term segregation review did not meet the codes of practice.
- Key performance indicators were in place and monitored as part of the clinical governance process.
- Ward managers reported sufficient authority to make decisions and adjust staffing levels when needed and felt supported by senior managers. Administration support was provided to the wards.
- Individual wards had risk registers in place. Staff were also able submit issue the providers risk register.

Leadership, morale and staff engagement

- Overall sickness rate was low between June and November 2017 at 3%.
- At the time of inspection there were no reported cases of bullying and harassment. However many staff did not feel confident to raise concerns.
- Most staff were aware of the whistle-blowing process. The CQC received numerous whistle- blowing's before,

during and following inspection. Common themes included unsafe staffing numbers, poor care and treatment provided to patients and lack of support and action from senior management when concerns were raised.

- Some staff told us that they felt able to raise concerns without fear of victimisation. Others did not. Overall, 15 staff did not feel that managers would take action to address concerns therefore many choose not to raise concerns. Staff described management as unapproachable and some staff feared they would be dismissed if they made challenges. Other staff were unmotivated to raise issues as they felt that no action would be taken.
- The provider told us that they had a process in place for staff to raise concerns, this included a staff forum.
- Staff we spoke with had low morale; whilst some staff were passionate about the care they gave to patients they were dissatisfied about the way in which they were treated, the inadequate numbers of staff on the ward and the lack of action and support from management. There was no sense of empowerment.
- Senior managers were aware of staff morale issues. They had held a staff consultation meeting in November 2017 that seven staff attended.Staff identified the following issues impacting morale; challenging patients that are inappropriately placed, inconsistent treatment of staff in disciplinary processes, staff feeling underappreciated and the expectation to take on tasks outside of their role. Staff did not feel valued, supported or listened to. Low staffing on wards left staff to feel unsafe and anxious, lack of support and debrief following incidents. The provider had developed an action plan following the consultation to address the concerns raised.
- We observed some positive team working on the wards and some staff described their immediate managers as supportive. However, ward managers worked across two wards so were not always available.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that ligature risks assessments are robust and that they effectively mitigate risk where there are poor lines of sight.
- The provider must ensure that action is taken to ensure that premises are kept clean and properly maintained.
- The provider must ensure that patients are not unlawfully deprived of their liberty.
- The provider must ensure that there are robust processes in place for the management of medication.
- The provider must ensure that the clinical governance arrangements are robust and improve standards of care and treatment for patients.

Action the provider SHOULD take to improve

- The provider should ensure that staff use radios and bleeps effectively in responding to emergency situations.

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 11 HSCA (RA) Regulations 2014 Need for consent • Informal patients were not always permitted or supported to leave the ward upon request. • There were two care plans that described informal patients' being detained under the Mental Health Act should they try to leave the ward. This was a breach of regulation 11(1)

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 • Ligature risk assessments were not robust, specific or include detailed mitigation to manage risk. • There was out of date equipment in clinic rooms. This was a breach of regulation 12, (1) and (2) (b)(e)

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 clinical governance systems were not robust and did not improve the standards of care and treatment for patients. This was a breach of regulation 17, (2)