Lakeside

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker

Chief Inspector of Hospitals.

Overall summary

We rated Lakeside as inadequate because:

- The provider did not manage environmental risks to patients effectively. Ligature risk assessments on all eight wards were not accurate and did not mitigate all risks. The service did not exclude admissions of patients with self-harming behaviours.
- Staff were not carrying out and documenting all checks on all patients. We found gaps in patient observation records on three wards. This placed patients at risk.
- Staff were not adhering to the Mental Health Act Code of Practice in regards to seclusion and long-term segregation. There were gaps in documentation and staff did not always follow the correct procedures. Staff did not complete seclusion records in full. Reviews of four patients in long-term segregation were not in line with the Mental Health Act Code of Practice.
- Staff did not manage equipment or medicines safely. Two clinic rooms contained out of date equipment. We found unlabelled, 'patient-only' medication in clinics on three wards. Staff did not accurately record patients' allergies on medication charts on four of the eight wards.
- The wards were not always staffed safely. Between November 2016 and October 2017 Staff turnover was at 35%. As a result, the service had been running with low levels of registered staff . In addition, the service had a high level of new and inexperienced staff and relied heavily on agency staff. Managers did not ensure that all shifts were staffed to the required establishment.
- The provider did not ensure that staff had adequate training or supervision. Not all staff had completed the induction training. Compliance with mandatory training was low for bank staff and low in some areas for permanent staff. Managers were not reviewing staff performance and development needs. The overall compliance with appraisal was low at 36%. The provider did not ensure that bank staff received supervision.
- Staff did not ensure that all confidential patient information was stored safely. We found confidential patient information left unattended in communal areas on two wards. We found handover documentation left in a toilet.
- The quality of care planning was poor. Care plans were not always personalised, recovery focused or accurate. Staff did not capture patients' views in care plans. We saw limited evidence in care records of staff supporting patients to make decisions.
- Engagement and activity levels were low. Patients spent long periods asleep or in their room alone. We saw little evidence of activities and therapy taking place. Staff were not prompting or supporting patients to improve their engagement. The service provided a

Summary of findings

limited range of psychological interventions that were recommended by the National Institute of Health and Care Excellence. Some but not all patients' had sensory profiles and formulations in place.
- Not all staff were caring in their interactions with patients. Interactions between staff and patients were not positive and supportive on three wards. Staff did not always take action to ensure that patients' dignity was maintained.
- Staff did not discuss actions and learning from complaints at clinical governance meetings.

However:

- The units complied with Department of Health guidance on eliminating mixed sex accommodation.
- All wards had emergency medical equipment in place.
- Staff discussed patients' care and treatment at monthly multi-disciplinary meetings. Staff completed risk assessments upon admission and updated them at regular intervals.
- The provider held daily meetings where key staff would meet to review issues across the service including staffing and incidents.
- The ward environments had improved, they were clean and tidy, and some had been decorated.
- Most staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation. Staff told us that morale was slowly improving.
- Staff were aware of and usually followed safeguarding procedures and the provider had a positive working relationship with the local safeguarding team.

Summary of findings

Contents

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Lakeside

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 in order to move on to residential or supported living. At the time of inspection, three units, Gifford 1, Gifford 2, and Elstow 5 were closed and unoccupied due to refurbishment.

Eight units were open and there were 45 patients receiving care and treatment.

- Ashwood unit provides ten beds for women. This is a locked unit for people with autism, personality disorders, and challenging behaviours. The unit is split over two floors and has an upstairs 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 4 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 a behavioural support unit, for patients who require intensive support from staff due to risk behaviours.

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 its name in January 2018. The service registered with the CQC in 2005. The CQC has carried out eight inspections since registering in 2005. 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. Following that inspection, CQC rated the provider as inadequate overall. We rated safe and well led as inadequate, effective, and caring as good and responsive as requires improvement.

In September 2016, CQC undertook a focused, announced inspection to re-assess the safe and well led key questions. We found some improvements and revised the rating of both key questions to requires improvement. At that time, we also revised the providers' overall rating to requires improvement.

This planned comprehensive inspection had been announced however, we carried out unannounced focused inspection on 27 to 29 November 2017 and 12 December 2017 in response to concerns raised with the CQC. These included concerns regarding:

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

Following this inspection we told the provider they must take the following actions 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.

We also told the provider that it should take the following actions to improve:

Summary of this inspection

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

Our inspection team

The inspection team leader was Deborah Holder.

The team that inspected Lakeside consisted of an inspection manager, three CQC inspectors, a Mental Health Act reviewer, and six 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 inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all eight wards at the hospital site and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 16 patients who were using the service
- spoke with 48 staff members; including the registered manager, ward managers, doctors, nurses, social workers and therapy staff
- attended and observed one hand-over meeting
- spoke with one carer
- collected feedback from eight patients using comment cards
- looked at 15 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
- received feedback on the service from eight commissioners of 19 patients placed at Lakeside.

What people who use the service say

We spoke with 16 patients who were currently receiving treatment and reviewed feedback from eight comments cards.

- Six patients told us that they felt safe and that staff were kind and helpful.
- Two patients told us that they did not feel listened to and that staff were unhelpful.
- Two patients told us that they felt involved in their care plans.

Summary of this inspection

- Five patients told us that they disliked the food and that they would like more variety. Some patients would like the opportunity to cook for themselves.
- One patient told us that their leave was cancelled due to staffing issues.

Four patients told us that they would like more activities, particularly over the weekend. Patient would like the opportunity to use the gym.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- The ligature risk assessments that had been undertaken on the eight wards that were open at the time of the inspection were not accurate and did not mitigate all risks effectively.
- We found gaps in observation records on three wards. Staff did not observe all patients in accordance with their care plans. We reviewed five seclusion records and found gaps in all records.
- Staff did not follow the Mental Health Acto Code of Practice for seclusion and long-term segregation. They failed to maintain full and accurate documentation relating to the use of seclusion. They did not complete reviews for all four patients in long-term segregation in line with the Mental Health Act Code of Practice
- Two clinic rooms contained out of date equipment.
- The management of medication was not robust in all areas. There were discrepancies with recording of patient allergies and we found unlabelled patient only medication on some wards.
- The provider did not ensure that the wards were staffed safely. Managers did not ensure that all shifts were staffed to the required establishment. Between November 2016 and October 2017, staff turnover was high at 35%. As a result, the service had a high level of new and inexperienced staff and relied heavily on agency staff. Due to the low numbers of registered nurses, there was not always a registered nurse present in the areas of the wards that patients used. The wards were unable to fill all shifts at all times.
- A high number of bank staff had not completed all training that the provider considered essential for all staff. Overall, this group of staff had only completed 53% of mandatory training courses. Fewer than 75% of permanent staff had completed some training courses that the provider considered to be essential.
- The provider did not maintain full and accurate documentation relating to the use of seclusion.

However:

- The units complied with Department of Health guidance on eliminating mixed sex accommodation.
- Staff were aware of safeguarding procedures and how to report an incident.

Summary of this inspection

- Staff completed risk assessments upon admission and updated them at regular intervals.
- All wards had emergency medical equipment in place.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Appraisal compliance rate was low at 36%.
- Bank staff were not receiving supervision.
- There were limited psychological interventions taking place.
- Staff did not always keep accurate or detailed records of assessments of patients' mental capacity. They did not record the decision-making process or how they supported patients to make decisions. There was little evidence that staff supported patients to make decisions.
- Care plans were not always accurate or contained sufficient information to address the specific needs. We found discrepancies or missing information in seven out of the 15 care records, we reviewed.
- Staff did not keep all patient information secure. We found patient information left unattended in areas to which other patients had access.

However:

- Overall 96% of staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Overall, 86% of staff had received training in the Mental Health Act.
- Staff explained to patients their rights on admission and routinely thereafter.
- Monthly multi-disciplinary meetings were taking place where staff discussed patients' care and treatment.
- Overall compliance with supervision was 84% for permanent staff.
- Managers were in the process of auditing and reviewing activity and treatment pathways.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- From our observations, we concluded that not all staff were caring in their interactions with patients. We observed staff engagement on three wards was not in a caring or compassionate manner.

Summary of this inspection

- Not all staff knew the patients that they were caring for, their risks, or care plans. One nurse in charge of the ward did not know the patient group; their observations or care plans. Another member of did not know the patients' names.
- There was little evidence of patient involvement in care plans and staff were not routinely documenting how they were supporting patients' to be involved in their care plans or if patients were provided a copy.

However:

- Some patients confirmed that staff were respectful, caring and that they felt safe.
- Some patients praised the permanent staff and described them as friendly and approachable.
- There was an advocacy service available that some patients were aware of and had accessed.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There was a lack of space for therapeutic activities to take place.
- Patients spent long periods across the week asleep or in their room. We saw little evidence of activities and therapy taking place. Patients told us that they would like more activities particularly over the weekends.
- Staff did not prompt or support patients to improve their engagement.
- Patients told us that they would like greater variety of meals and would like the opportunity to cook for themselves.

However:

- There were appropriate rooms off the wards for family visiting. Some family members visited on the wards.
- All wards had access to an enclosed garden area.
- Most patients knew how to complain. The provider responded to complaints in a timely way.
- There was appropriate access to spiritual support.
- Some patients personalised their bedrooms.

Are services well-led?

Inadequate

We rated well led as inadequate because:

- Managers did not ensure that all staff received mandatory training.

Summary of this inspection

- Managers did not ensure that bank staff received supervision in line with their policy.
- Staff performance and development needs were not reviewed in line with policy and compliance rate to appraisal was low at 36%.
- Managers were not ensuring that all staff completed induction and the mandatory training required.
- At times, there were insufficient numbers of staff to cover the shifts to ensure that patients were safe and their needs met.
- Mental Health Act procedures were not followed in relation to seclusion and long-term segregation.
- Actions and learning from complaints was not routinely discussed at clinical governance meetings.

However:

- Most staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation.
- Staff felt that morale was slowly improving and that managers had made positive improvements to the ward environments.
- Safeguarding procedures were followed and the provider had a positive working relationship with the local safeguarding team.
- Clinical staff participated in a variety of audits.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Overall, 86% of staff had received training in the Mental Health Act.
- The provider had a Mental Health Act policy in place which staff could refer to if needed.
- Staff on the wards informed patients of their rights.
- Doctors granted patients Section 17 leave following assessment of risk. We saw that forms were signed and in date.
- The management and review of long-term segregation was not in line with the Mental Health Act Code of Practice.
- Staff completed consent to treatment forms. Staff attached copies of paperwork to medication charts.
- Written information on the rights of detained patients was available across the wards and visible.
- Independent Mental Health Advocacy services were available to support patients. All wards displayed information on advocacy.
- The service carried out regular audits to ensure that the Mental Health Act was correctly applied. We saw evidence of follow up and correction when the Mental Health Act administrators identified issues.
- There was a Mental Health Act administrator and staff knew how to contact them for advice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Overall, 96% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training.
- We interviewed staff and asked them about their knowledge of the Mental Capacity Act. They were able to describe an understanding of the practical application of the Mental Capacity Act and could provide basic examples of how they would transfer this knowledge to their practice on the wards.
- Mental capacity assessments were present where required. Four out of 15 records reviewed showed that staff did not keep accurate or detailed records of assessments of patient capacity. Staff did not record the decision-making process or how they supported patients to make decisions. There was little evidence that staff supported patients to make decisions. Staff made decisions in the patients' best interest where patients had capacity to make them. There was one patient cared for under a Deprivation of Liberty authorisation at the time of inspection. Staff made two applications for authorisation since January 2017; one of which was authorised.
- The service had a Mental Capacity Act policy in place that staff were aware of and could refer to when required.

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

- All wards had blind spots due to the layout. 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 nursing observations were always completed. We found gaps in enhanced observation records on Cooper 2, Elstow 3 and Ashwood ward. The security folder on Elstow 2 was incomplete; patient names, observation levels were not routinely filled out for all patients.
- The service had closed circuit television (CCTV) installed which was used as a recording tool and some observational mirrors were in place. Following inspection the manager told us that they had ordered additional observation mirrors for the service.
- Wards had up to date ligature risk assessments, managers had reviewed the assessments in February 2018. A ligature point is anything, which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The service did not exclude patients with self-harming behaviours and with a history of ligaturing and at the time of inspection had patients with a history of self-harming behaviours.
- The ligature risk assessments did not identify all ligature points across the wards and garden areas. Across all wards, radiator covers were assessed as low risk and not an obvious item for securing a ligature, despite numerous anchor points. The kitchen serving hatches had robust wall brackets that were anchor points; these had not been identified on the assessments. All gardens had door restrictors (a potential anchor point) that had not been identified on the assessments. The external windows across the wards had window restrictors in place (an anchor point). The mitigation for these was that patients would be risk assessed for access and / or supervised at all times. Despite the mitigation, we found no patient risk assessments in place for access to the garden and the door to the gardens were left unlocked across the hospital. The window restrictors were identified as low weight bearing; this was tested and was incorrect. Internally across the wards window handles were identified as low weight bearing, these were tested and many were found to be weight bearing. Due to the design of the windows, it was possible to place a ligature securely. Three windows had metal wires in place of external window restrictors; managers had not identified these on the assessments and they were a ligature point. The provider had removed some ligature points since our last visit, but this had not been reflected in the updated ligature risk assessments. These assessments included items that had previously removed by the provider. For example, trampolines, goal posts in gardens, and storage cupboards in bathrooms.
- On Cooper 1, the mitigation for all ligature points identified in the kitchen was that the door was kept locked. We observed the kitchen door was left open and four staff told us that the kitchen was usually unlocked. The garden had not been included on the ligature risk assessment, which contained several ligature points.

Inadequate

Wards for people with learning disabilities or autism

- On Cooper 2, the communal bathroom had grab rails to assist those with mobility issues and the garden contained a swing; these had not been included on the ligature risk assessment.
- On Cooper 3, the garden swing had not been included on the ligature risk assessment.
- On Elstow 1, the door handles on the communal toilet, staff toilet and door in the upstairs corridor, the radiator cover, and the window handles in the quiet room had not been identified on the ligature risk assessment. All were potential ligature points.
- On Elstow 2, the dining room and quiet room had numerous ligature points. The mitigation to manage these risks was that they were high visibility areas. During the inspection, we noted that staff were not observing these areas at all times. The lounge had a robust wall mounted bracket and the garden contained a wall mounted basketball hoop, neither had been included on the ligature risk assessment. At the time of inspection, there were three patients on this ward that were on enhanced observations levels to mitigate individual risks.
- On Elstow 3, the handrail on the stairs had not been identified on the ligature risk assessment. One patient on Elstow 3 attempted to self-ligature in December 2017. This patient had a local risk assessment and updated safety plan in place.
- On Elstow 4, the kitchen door was assessed as having no fixing point, despite a metal door closure in place. The communal toilet door handle was a ligature point; whilst it had been identified on the assessment, the mitigation was that it was a high visibility area. There was no means to observe patients in the toilet and the door was unlocked. There were three door handles on the ward that had not been identified as a ligature point on the assessment; two bedroom doors in the first floor corridor and one downstairs toilet door with an external handle. One patient on Elstow 4 had tied a ligature in September 2016 and had voiced suicidal ideation in January 2018. This patient did not have a local risk assessment or an updated safety plan in place.
- On Ashwood, the window handles in the communal bathroom had not been identified as a ligature point.
- The hospital complied with Department of Health guidance on eliminating mixed sex accommodation, as there were separate wards for male and female patients.
- There were clinic rooms on each ward. Clinic rooms were small but were clean and organised. All wards had emergency equipment in place. There were physical health folders for all patients across the clinics.
- We were not assured that effective weekly checks of stock and equipment were taking place on all wards. We found issues in five clinics.
- On Elstow 1, there was out of date dressings and glucometer strips. Two medication charts did not identify the patients' section status. One sharps disposal bin was unlabelled. These concerns were subsequently addressed by staff during the inspection.
- On Elstow 2, the first aid kit contained two out of date burns kits. Rapid tranquillisation had been given on one occasion but not recorded in the providers own internal monitoring book. The registered nurse was asked about the process for reporting medication errors but was unclear of the providers' process. This was despite the guidance issued by the provider upon commencement of employment and the provider's own medication policy, which was available for all staff to access. One patient's allergies had not identified on the medication chart but were recorded on their physical health folder. The provider addressed the out of date items after the inspection.
- On Elstow 3, one patient's allergies were not recorded on their medication charts but were report on their physical health folder.
- On Ashwood, discrepancies were noted between the recording of two patients' allergies on their medicines chart and their physical healthcare folder.
- The service had one seclusion room, located on Cooper 1 ward. The manager had made significant improvements to this area since last inspected and it met the Mental Health Act Code of Practice. However, we noted that the structure that covered the heating system was not robust and flexed upon contact.
- We observed that wards were generally clean and tidy. Most wards had been refurbished in recent months, they had been decorated, and bathrooms and toilets had been refitted. Some wards had new furniture and curtains in place. There was no radiator in Elstow 2 bathroom and the room felt cold.
- The Patient-Led Assessment of the Care Environment (PLACE) score between December 2016 and March 2017 was 62% for cleanliness and 67% for appearance. This

was below the national average. We noted an improvement in the cleanliness of all ward environments since the last inspection in November 2017.

- We found some gaps in cleaning records that we checked however, these areas were clean on inspection.
- The provider had conducted an audit for autism-friendly environments and identified issues including; noise in some wards due to the alarm systems, lack of quiet areas on some wards and bland decoration on some wards. We observed that the provider had taken steps to address the alarms and decoration.
- The service had a response alarm system in place. We observed that staff activated alarms when they required assistance. We observed three occasions where staff responded by walking slowly to the ward that required assistance. We reviewed records of response tests that showed quick response times. Managers told us that staff were encouraged to log any inappropriate response times as an incident. On Ashwood ward, it took staff four minutes to respond to the alarm tested in the bathroom. We noted that alarms for patients to call for assistance were not situated in reach of the bath and so could not be used by patients to raise the alarm if they required support in the bath.

Safe staffing

- Managers told us that their set staffing establishment was one staff member to four patients as a minimum but they aimed for one staff member to two patients.
- In December 2017, there were 28 registered nurse posts and 51 support worker posts vacant. This equated to 69% of registered nurse posts and 26% of support worker vacant posts. At inspection, there were 14 registered nurse posts and 33 support worker posts vacant. Two of the four managers interviewed did not have oversight of their ward vacancies.
- Between 2 October 2017 and 31 December 2017, 1,557 shifts were filled by agency and 240 shifts by bank staff. Within the same period, 119 shifts were unfilled therefore, not all shifts had the optimum staff on shift at all times. We saw that at times some wards had additional staff on shift above their planned establishment.
- Managers told us they tried to book the same agency staff to the wards in order to provide consistency. One agency nurse in charge of a shift at the time of the inspection did not know the patients, their observations, or the ward-staffing establishment. The provider took action to support this staff member once the Commission had raised their concerns with them.
- One nurse in charge of a shift left the ward leaving three male staff on an all-female ward. The provider subsequently investigated this incident and took action to prevent any reoccurrence.
- Four commissioners expressed concerns regarding the continuity of care provided by agency staff.
- Sickness rates were low at 2.7%
- Overall staff turnover between November 2016 and October 2017 was 35%. This equated to 84 members of staff leaving the provider.
- Managers reported that they were able to adjust staffing numbers as required to take account of case mix and additional observations. If patients required nursing on one to one then additional health care assistants would be booked to cover this.
- Registered nurses were not visible in communal areas on all wards.
- We saw evidence of patients having one to one time with their named nurse or key worker.
- Four staff and two patients told us that leave and ward activities were sometimes cancelled due to staffing issues on the wards.
- Physical interventions such as routine and ongoing monitoring of physical health were generally taking place. However, staff were not routinely documenting when patients declined routine interventions such as weight monitoring. We found gaps in the documentation for recording weight and food and fluid charts on Cooper 2. On Cooper 1, staff had been instructed on 23 February 2018 to fill out a stool chart for a patient; this was not in place at the time of inspection.
- Staff told us that there was adequate medical cover day and night. We found that doctors did not always complete seclusion medical reviews for patients within the required timeframes on three occasions'.
- There were 19 elements to mandatory training. Overall compliance for permanent staff was at 81%. There were elements of training where compliance fell below 75%; positive behavioural support 67%, safeguarding 67.5%, fire safety 71%, moving and handling 70% and infection control 70%. Following inspection, the provider told us that these training figures had improved.

- Bank staff overall compliance with mandatory training was significantly lower at 53%.

Assessing and managing risk to patients and staff

- Between January 2017 and December 2017, there 27 episodes of seclusion reported across the service. Seven of these in relation to Cooper 3 patients, six for Ashwood patients, four for Elstow 2 patients, five for cooper 1 patients, two for Elstow 3, three for Elstow 5 (patients on Elstow 4 at the time of the inspection). On 11 occasions staff secluded patients in bedrooms or other rooms that were not a designated seclusion room. Between January 2018 and March 2018, there were four episodes of seclusion.
- The providers' practices around seclusion were not in line with the Mental Health Act Code of Practice or their own policy. We reviewed five seclusion records and found them to be incomplete; there were discrepancies, gaps in paperwork, and observations were not completed. We were not assured that reviews were taking place in line with guidance.
- The first record had discrepancies on the time the doctor arrived. This doctor did not arrive within the hour. Staff did not document the rationale for seclusion in bedrooms, or any discussion regarding moving the patient to a more appropriate environment. One nurse signed the paperwork to end seclusion, the same nurse that initiated the seclusion.
- The second record did not clearly indicate where the patient was initially secluded. Staff told us they moved the patient to their bedroom, as the door to seclusion was not robust.
- The third record did not document the rationale for secluding in a bedroom, or any discussion regarding moving the patient to a more appropriate environment. The four-hour medical review was not completed. The same nurse that initiated the seclusion completed the two-hour nursing review; only one nurse completed this review.
- The fourth record did not document the rationale for secluding in a bedroom or any discussion regarding moving the patient to a more appropriate environment. The doctor did not attend to review the patient, and staff consistently failed to complete the 15-minute nursing observations.
- A further record noted that a member of staff of the same gender should observe the patient; staff did not follow this care plan.
- Between June and November 2017 there were 877 incidents of physical restraint across the service involving 47 patients. One patient on Ashwood unit was restrained on 122 occasions; one patient on Cooper 3 was restrained on 190 occasions. Overall, Ashwood unit accounted for 23 %, Elstow 2 14 %, Elstow 3 13%, Cooper 1 17%, Cooper 3 16% of all restraints. There was one incident of prone restraint (face down). Following inspection, the provider told us that between January 2018 and March 2018 there were 558 incidents of physical restraint across the service and no prone restraints.
- We reviewed 15 care and treatment records and saw that staff completed a risk assessment of patients upon admission. One patient had a history of ligaturing and expressing recent suicidal ideation, there was no specific management plan or individualised risk assessment in place as identified in the wards ligature risk assessment.
- Staff usually updated risk assessments following incidents and at regular intervals, staff used the company's risk assessment tool to capture areas of risk.
- 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 informal patient had a care plan in place that stated they must be escorted by staff in the community even though he had expressed a wish to go out on his own. On one occasion, the patient became agitated, as staff did not support leave.
- The provider had policies and procedures for use of observation and searching patients. Staff only searched patients where indicated by risk.
- Staff did not always undertake observations of patients assessed as being at risk in line with the provider's policy. We found gaps in observation records on Cooper 2, Elstow 3 and Ashwood wards. We reviewed three enhanced observation folders on one ward; we found gaps in all records. On one occasion, staff recorded "no staff to cover" and the patients' observations were not completed for one hour 45 minutes. There were gaps in recordings for an hour on another occasion. We found gaps in a third record over the course of a week. On another ward, we found gaps in one patient's records for four hours and 30 mins. This patient was on 15-minute

intermittent observations. On a third ward a patient on 15-minute observation absconded from the ward, the observations had not been completed and his absence was not noted for several hours.

- Staff told us that they used restraint as a last resort however, between June and November 2017 there were 877 incidents of physical restraint. Between January 2018 and March 2018 there were 558 incidents of physical restraint across the service and there were no prone restraints. Overall, 94% of permanent staff were trained in restraint techniques as of March 2018. Only 67% of permanent staff had completed positive behavioural support training, this is an identified strategy for supporting patients with challenging behaviour.
- The use of rapid tranquilisation followed National Institute for Health and Care Excellence guidance. We found one incident where staff did not record the administration of rapid tranquilisation in their own internal monitoring book.
- We reviewed the providers' policy and practices on long-term segregation and found they did not meet the Mental Health Act Code of Practice. There were four patients managed under these arrangements on Cooper 3. Some of these patients had been managed under this arrangement for an extended period of time. An approved clinician was not completing daily reviews of patients that had been in long-term segregation. The provider was not completing weekly multi-disciplinary reviews of patients in long-term segregation. The provider had moved to monthly reviews for all four patients but these were not taking place consistently. Following inspection, the provider shared information that showed that four of the 31 monthly reviews had not taken place, a further eight reviews did not have the responsible clinician in attendance. No external hospital reviews had taken place; however, the provider had taken steps to seek external reviews without success. Independent mental health advocates were not routinely involved in long-term segregation reviews. The provider did not notify the safeguarding team of all long-term segregations. One patient had three different reintegration's plans in place; neither patient nor staff knew which plan was accurate.
- Overall 67.5% of staff were trained in safeguarding, this was mandatory training. Staff we spoke with could explain what a safeguarding incident was and how to raise an alert.
- Medicines management including storage, dispensing, and medicine reconciliation was not robust on all wards. We found unlabelled patient-only medication for physical health issues on Cooper 1, Elstow 1, and Elstow 2 (cream and eardrops). We found discrepancies between allergies reported on the medication charts and physical health folders on Elstow 1, Elstow 3, and Ashwood wards.
- There were procedures in place for children to visit the service. There was no dedicated child visiting room but a meeting room off the ward could be used for child visits.

Track record on safety

- There were two serious incidents that required reporting since September 2017, both in relation to physical health issues.
- Between January 2017 and January 2018, the provider reported 114 safeguarding concerns to the CQC. Concerns included allegations against staff, patient on patient assaults and incidents of self-harm.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents on the provider's electronic reporting system. Managers reviewed reported incidents.
- Staff reported most incidents that should be reported. Staff could describe the safeguarding process, and immediate safeguards they could put in place to protect patients.
- Staff told us that they were open and transparent and explained to patients and carers when things went wrong. Some staff were aware of duty of candour.
- Incidents were discussed at daily morning meetings, handovers, and team meetings. Lessons learnt were shared across the service. Staff told us they received feedback following serious concerns and were able to describe incidents from other wards. Most staff confirmed that de-briefs and support was provided following incidents.

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

Inadequate

Wards for people with learning disabilities or autism

Inadequate

Assessment of needs and planning of care

- Lakeside describes itself as a specialist service providing rehabilitation in order to support patients to move on to residential or supported living, offering a range of specialist services to facilitate this. On inspection, we found that very few staff had the necessary skills to work with the complex and challenging patient group. The average length of stay of patients discharged between November 2016 and October 2017 was 774 days.
- Assessments were not always detailled and the treatment and therapy programme was not focused on rehabilitation or sufficient to move patients on in a timely manner.
- We reviewed 15 care records. Care records showed that a full physical health examination was usually completed within two weeks of admission. The provider's physical health audit conducted in February 2018 identified four patients across the service that had an out of date assessment; the newly recruited practice nurse took action to address this.
- Ongoing physical health monitoring was not robust in all areas. We found physical health issues were not accurately identified in one patients care plan; the care plan lacked detail and the Health Action Plan was not in place. Another patient did not have the recommended stool chart in place and the medication support plan did not provide guidance regarding identifying side effects. For another patient the hospital passport was out of date and did not list the current prescribed medication. Another patient's risk management plan for epilepsy was not patient specific and made reference to another patient. We found evidence of the plan not being followed and medication administered after 10 seconds instead of the prescribed 10 minutes in the care plan. One care record failed to capture all known physical health issues across all paperwork. The hospital passport and physical health assessment was missing. Allergies were not always documented accurately. The provider had recently recruited a practice nurse.
- The provider completed care record audits. A recent audit showed that overall compliance with their own criteria was at 55% in February 2018. This was a significant decline from the previous audit in August 2017. Elstow 3 had the highest compliance rate of 63% and Cooper 3 the lowest at 39%. The provider had identified areas for improvements.
- Four commissioners expressed concerns regarding the quality of care planning and assessment. They told us that there was a lack of sensory assessment, patient formulation, and documentation around personal care support. Care plans did not identify approaches to increase engagement or reduce aggression.
- On inspection, we found that sensory assessments and patients formulations were not routinely in place and we found little evidence of staff supporting patients to increase engagement. The quality of care plans varied across the service. Most care plans were holistic however; they were not always accurate or contained sufficient details to address individual needs. Some care records contained up to date information and were detailed others were not. Care plans were not always person centred or recovery focused. A new head of therapies started in January 2018 and they were reviewing the provision of therapies to patients.
- We identified that there were discrepancies or missing information in seven of the 15 care records, we reviewed. One patient had eight care plans in place. Four of these care plans lacked detail for example; the self-harm and neglect care plan did not identify any coping strategies, or distraction techniques to reduce behaviour. One to one psychology input was identified within the plan but the patient was not receiving this intervention. The care plan for managing allegations against staff did not identify significant history or safeguarding procedures. The patient had allergies but these were not identified in the physical health care plan. One patient had integrated treatment plan and risk management plan for community leave had the incorrect legal status. There was evidence that staff had updated paperwork however, it contained inaccurate dates. For example, the post admission meeting predated the patients' admission to the service. One care record contained conflicting diagnosis.
- Most information needed to deliver care was stored securely and available to staff. We found two enhanced observation folders left unattended in communal areas on Elstow 2. We also found the security folder had been

left unattended. We found handover notes in a staff toilet. The provider took appropriate action at the time of inspection and raised these issues as security breaches.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication across the service. Antipsychotic medication was prescribed within the British National Formulary limits and physical health monitoring was in place.
- We saw little evidence of psychological therapies as recommended by National Institute for Health and Care Excellence. On inspection, we identified similar issues. The quality of therapies provided to enable recovery and rehabilitation were not in place. Not all patients' had highly developed positive behavioural support plans or sensory assessments in place.
- Commissioners of 10 patients expressed concerns regarding the level of therapy and activity offered. They told us there were limited one to one therapies offered, minimal formal treatment, and no strategies in place to improve engagement.
- We reviewed the providers' engagement data for February 2018, and found that 75% of the time most patients had 25 hours of planned activity on their individual timetables. The actual level of delivered was low in comparison to what was planned. Weekly hours of accepted or delivered activity ranged from 11 hours on Elstow 1 to 20 hours on Cooper 3. The provider told us that they reviewed patients' timetables weekly to ensure that patients were offered appropriate activities.
- Patients had access to physical healthcare. Staff referred patients to specialists such as diabetic nurses, and dentist when required.
- Staff completed assessments of nutrition and hydration and care plans were in place for specific patients.
- The service used a variety of tools to capture outcome measures including Health of the Nation Outcome Scale.
- Clinical staff participated in a variety of audits, including medication, knowledge, and practice of the safeguarding procedures, reducing restrictive practice, infection control, and compliance with the Mental Health Act.

Skilled staff to deliver care

- Patients received care and treatment from a range of professionals including nurses, doctors, support workers, psychology, occupational therapy, and speech and language therapy. The therapy team was relatively new in post and still establishing treatment models, and was being embedded into the service at the time of inspection.
- Staff experience varied; there were large numbers of staff that were new to the service. Some staff were still learning their roles and getting to know the patients. As part of their induction new staff had one week of supernumerary work to allow them to get to know the patients on their unit before starting independent work on the unit.
- In January 2018, the provider introduced a new induction programme. Staff that had attended this were positive about the quality of training and support they received prior to working on the wards. All staff received a two week induction programme.
- Between January 2017 and December 2017, overall compliance with supervision was 84% for permanent staff. At the time of inspection, the provider told us that the supervision compliance for permanent staff was at 81%.
- Between June 2017 and October 2017, no bank staff received supervision. We asked the provider for updated supervision compliance for bank staff however, this was not provided.
- We were not assured that managers were reviewing staff performance and development needs. Overall compliance with appraisal was very low, only 36% staff had received an appraisal in 2017.
- The service held a variety of staff meetings taking place across the service, including monthly senior healthcare meetings, unit managers meetings, nursing meetings, and staff forums. Reflective practice sessions were not taking place however; there was a programme in place for these to start in the near future.
- There was a programme of additional non-mandatory training available to staff and compliance with this varied. Topics included introduction to learning disability 33%, first aid at work 52%, introduction to self-harm 39%, person centred planning 23%, understanding the perspective of people we support 28%, introduction to risk assessment 14%, immediate life support 78%, introduction to autism 84%, risk assessment level 2, 81%.

Inadequate

Wards for people with learning disabilities or autism

- Managers addressed poor staff performance when required. Between December 2016 and October 2017, 23 staff members were suspended pending investigation. In addition, five staff received additional supervision.

Multi-disciplinary and inter-agency team work

- The multi-disciplinary team held monthly meetings where patients' care and treatment were discussed. Staff described supportive working relationships across the multidisciplinary team.
- The provider held daily meetings where staff from each ward would meet to review key issues within the service. Key information was then fed back to the wards.
- Managers reported effective working relationships with teams outside of the organisation, for example, with the local authority safeguarding team. Nursing staff invited community care coordinators and commissioners to multidisciplinary meetings and reviews.
- We reviewed the documentation from two care and treatment reviews. The risk assessments in one record were up to date but not accurate and did not reflect the patient's current support plans. In the second record the support plans and risk assessment were not accurate or up to date.

Adherence to the MHA and the MHA Code of Practice

- Staff completed appropriate Mental Health Act paperwork upon admission. The Mental Health Act administrators had good and thorough oversight of the service.
- Staff contacted the Mental Health Act administrator if they needed any specific guidance.
- Leave forms were in place where required. Those we examined were signed and in date.
- Overall, 86% of staff had received training in the Mental Health Act. Staff understood their roles and their responsibilities under the act.
- Consent forms and current medication forms were kept together so staff could check patients' consent for medicines.
- Staff explained patients' their Section 132 rights on admission and routinely thereafter. The Mental Health Act administrators monitored this.
- Administrative support and legal advice on implementation of the Mental Health Act and code of practice was available.
- Staff completed detention paperwork correctly; it was up to date and stored appropriately.
- The provider carried out regular audits to ensure that the Mental Health Act was applied correctly.
- Patients had access to Independent Mental Health Advocacy (IMHA) services. There were posters on all wards providing information about this service.
- Staff were not following the Mental Health Act Code of Practice for long-term segregation and seclusion.

Good practice in applying the MCA

- Overall 96% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training.
- There were two Deprivation of Liberty Safeguard applications made since January 2017. Both applications were for patients on Cooper 2.
- Most staff we spoke with had an understanding of Mental Capacity Act.
- A Mental Capacity Act policy was in place that staff was aware of and could refer to for guidance.
- Mental capacity assessments were in place where required, some but not all were detailed. One assessment on Elstow 2 contained little detail of the assessment and methods used to support the patient to make a decision. Another patient was identified as having capacity but there were references in support plans of staff acting in the patient's best interest. One assessment on Cooper 1 recorded that it would be unwise for the patient not to accept the help identified but there was no corresponding capacity assessment or best interest decision documented.
- In 2017, the Service introduced Mental Capacity Act Champions who have been attending regular bi-monthly meetings with specialist Mental Capacity Act leads from Bedford. The Service continues to train new Champions.
- We saw limited evidence in care records of staff supporting patients to make decisions or to participate in discussions.
- Staff knew where to get advice regarding the Mental Capacity Act within the organisation.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, dignity, respect and support

Inadequate

Wards for people with learning disabilities or autism

- We observed that some staff were polite, respectful, and caring toward patients. They communicated appropriately whilst maintaining professional boundaries. However, on Cooper 2, we observed a staff member tell a patient on two occasions that they would call a rapid response team if they did not comply with their requests. This patient was not being aggressive. We observed another member of staff engage with the same patient with dignity and respect. We observed staff shout down the corridor at one another with no regard for the patients that were present in the area. On Elstow 1, not all staff knew all patients; we saw limited interactions between staff and patients and one member of staff called the patient by the wrong name. Male staff were completing observations on females in their bedrooms; this contradicted the patients care plans. On Elstow 3, staff permitted a patient to walk around in his underwear. Staff did not prompt or support the patient to put on trousers. This patient's dignity was significantly compromised as he was exposing himself on the ward.
- Some patients told us that staff were respectful, caring and that they felt safe on their wards.
- Six patients told us that staff were kind and helpful. Two patients told us that they did not feel that staff listened to them or offered support.
- Some staff demonstrated a good understanding of patient's individual needs, including care plans, observations, and risks.

The involvement of people in the care they receive

- On admission, staff told us that they gave patients a formal greeting and a 'welcome pack' about the ward, which explained catering, activities, and treatment.
- Patients did not always sign care plans and there was little evidence of patient involvement across the wards. Seven out of 15 care plans reviewed did not clearly evidence patient involvement. Most care plans were written in the first person with "I" statements but read as if written by staff.
- Staff did not always document when patients were offered or refused to sign their care plans.
- Patients had access to advocacy. The advocate visited the wards regularly. There were posters displayed across the ward and patients were provided with leaflets upon admission. Some patients were aware of and had accessed the advocacy, but not all. We noted that mental health act advocates were not routinely involved in long-term segregation reviews.
- Regular service wide patient meetings were taking place, this provided patients a forum to raise issues and provide feedback monthly.
- Family and carers were involved where appropriate. One carer told us that they felt involved in decision-making.

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

(for example, to feedback?)

Requires improvement

Access and discharge

- Average bed occupancy since January 2017 was 83%. The average length of stay of patients discharged from November 2016 to October 2017 was 774 days. Following inspection, the provider told us that the average length of stay across the service is 2.68 years which equates to 978 days.
- This was a rehabilitation service to support patients to move on however some patients had been within the service for over five years and had no active discharge plans in place.
- From November 2016 to October 2017, the provider discharged 17 patients, which equates to 30%. Patients were discharged to a variety of services including community based services and other hospitals. From January 2016 to October 2017, there had been four delayed discharges from the service due to delays in identifying appropriate placements.
- Staff told us that discharge planning started from admission. Some but not all patients were aware of their discharge plans. Some patients told us that they were waiting for appropriate placements to be identified. The service took steps to involve patients in their discharge process wherever possible.
- Referral to assessment time ranged from one to 13 days. The period between initial assessment and admission ranged from one to 59 days.
- The service accepted out of area placements routinely.

- Patients were not moved between wards unless clinically justified.

The facilities promote recovery, comfort, dignity and confidentiality

- Across the wards, patients had access to a lounge area with appropriate furniture, a TV, music and games. The therapy centre was a separate building from the wards and patients crossed a grassed area to access the building. It was a multi-functional space for therapy groups and leisure activities. Staff told us that at times, it was challenging to facilitate therapy alongside recreational activities in this building. There was a gym on site but; there was no gym instructor to support access to this at time of inspection. The service was supporting one member of staff to train as a gym instructor. Staff told us that there was a sensory room on Cooper 3 but that they did not have the key to access this facility. Therefore, we were unable to view this area.
- Patients had individualised timetables of activities in place. Activities were often recreational focused.
- We reviewed a sample of patients' individual timetables. Some patients were consistently declining activities on a daily basis and as a result, activity levels were low. On inspection, we saw little activity taking place and many patients spent large sections of the day asleep or in their rooms. There were activities offered across the week. Patients told us that they would like more activities particularly at weekends.
- There were no designated visiting rooms on the wards. There were meeting rooms in reception and visits took place at the activity centre. We observed two family visits taking place on the wards during inspection.
- Patients were permitted use of a ward phone to make phone calls. The service had recently agreed to patients accessing their own mobile phones following risk assessment.
- All wards had access to an enclosed outdoor space.
- Patients could choose meals from a daily menu. We spoke with 16 patients; five of them told us that they would like more choice in regard to meals.
- We saw that patients had access to drinks and snacks across the day. Patients confirmed this. On some wards, patients could access the kitchens independently.
- Some patients personalised their bedrooms. Patients were able to store their possessions securely in a safe in their bedrooms.
- Wards did not display patient friendly signage to aid orientation to the physical environment for those patients that might require it due to the nature of their disability.

Meeting the needs of all people who use the service

- There was access for wheelchairs for those that required help with restricted mobility to some wards. The hospital had no lift on the wards to support access to the first floors.
- The service had a range of leaflets available including information on patients' rights, how to complain, and advocacy. Staff used the walls and notice boards for displaying information. Staff told us patients were given a welcome pack upon admission.
- Staff had access to interpreters and translation services when required. Information could be requested in different languages if required.
- The hospital catered for all dietary and religious requirements. Patients and some staff told us that they would like more food choice.
- There was appropriate access to spiritual support.

Listening to and learning from concerns and complaints

- The provider received 52 complaints between November 2016 and October 2017. Overall, 21 were upheld, 12 partially upheld and 19 not upheld. Complaints were varied in nature with themes including complaints regarding staff attitude, behaviour, poor communication, and complaints against patients. No complaints were referred to the Ombudsman. Two out of eight patients that attended a focus group during the inspection told us that they had not received feedback after making a complaint.
- Between November 2016 and October 2017, the provider received 12 compliments.
- We reviewed five complaints. Four had acknowledgement letters sent within the providers timescales, four had formal responses and three had formal investigations; one was pending. Actions and learning from complaints were routinely discussed at clinical governance meetings.
- Some patients knew how to report complaints or raise concerns. Some patients did not feel listened to.

Inadequate

Wards for people with learning disabilities or autism

- Staff and managers told us that complaints were responded to immediately and often informally. All staff we spoke with knew how to respond to a complaint.
- Staff told us that they received feedback from investigations in team meetings and via the lessons learnt process. Staff were able to give examples of recent incidents that they had received feedback about.

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

Inadequate

Vision and values

- The provider had set visions and values; these were displayed in reception and on ward office notice boards. Managers and senior staff were aware of the visions and values.
- Some but not all staff demonstrated these values in their behaviours. Most staff we spoke with were passionate about helping patients and improving standards of care. However some staff did not know the patients they were caring for, did not ensure that patients dignity was maintained at all times and were not caring in there interactions.
- Most staff knew senior managers, told us that managers were visible, and visited the wards routinely.
- All staff we spoke with described recent improvement within the service over the last two months.

Good governance

- Managers did not ensure that all staff received appropriate training. Overall, 81% of permanent staff had received mandatory training. However, compliance in some areas was low. There were elements of training where compliance fell below 75%; positive behavioural support 67%, safeguarding 67.5%, MP fire safety 71%, moving and handling 70% and infection control 70%. Bank staff overall compliance with mandatory training was significantly lower at 53%.
- Between January 2017 and December 2017, overall compliance with supervision was 84% for permanent staff. At the time of inspection, the provider told us that the supervision compliance for permanent staff was at 81%.
- Managers did not have a system in place to ensure that bank staff were receiving supervision. Between June and October 2017, no bank staff received supervision. The provider did not provide updated bank staff supervision figures upon request.
- We were not assured that managers had oversight of staff performance and development needs. Overall compliance with appraisal was low, only 36% staff had received an appraisal in 2017. This was not in line with the providers' policy.
- At times, managers could not cover all required shifts to ensure that patients were safe and their needs were met. Managers offered staff overtime and used agency staff where possible to fill gaps. Managers told us they tried to book agency staff to specific wards to promote consistency.
- Clinical staff participated in a variety of audits around medication, knowledge, and practice of the safeguarding procedures, reducing restrictive practice, infection control, and compliance with the Mental Health Act.
- Staff confirmed that they received feedback from incidents and complaints and that lessons learnt from other wards was shared with them at team meetings, via emails and within supervision. Some staff we spoke with could describe recent incidents and lessons shared across the service.
- Safeguarding procedures were usually followed. The provider had established a positive working relationship with the local safeguarding team. Managers did not notify the safeguarding team of all long-term segregations.
- Managers did not ensure that staff consistently followed the Mental Health Act Codes of Practice in regards to seclusion and long-term segregation.
- The service used key performance indicators to monitor the performance of the team's compliance in key areas such as sickness, supervision, and training. These were discussed at clinical governance meetings however were not sufficiently improving compliance across all key areas such as supervision and mandatory training compliance for bank staff, some areas of mandatory training for permanent staff and appraisal rate across the staff group.
- The managers reported sufficient authority to make decisions and adjust staffing levels when needed and

felt supported by senior managers. Ward staff had administration support. Staff told us that they felt supported by managers and that senior managers were approachable.
- Managers had the ability to submit items to the providers risk register. In addition, there were ward specific risk registers.
- Managers' oversight of issues had not addressed risks in relation to environment risks such as ligature risk assessment, medication management and compliance with the Mental Health Act Code of Practice regarding seclusion and long-term segregation compliance.

Leadership, morale and staff engagement

- Overall sickness was at 2.7%.
- At the time of inspection, there were no reported cases of bullying and harassment. The CQC received 10 whistle blowing's between December 2017 and January 2018. Issues included staff reporting that they were not listened to when they raised concerns to the manager, concerns regarding safety and the quality of care and concerns that they would be dismissed if they raised issues. No whistle blowing's were received between the end of January 2018 and the date of inspection.
- Most staff we spoke with on inspection knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation. Most staff told us that managers were supportive and would listen and act on any concerns they raised. Four staff told us that ward managers were not always available as they covered two wards.
- Staff told us that morale was improving and that staff felt more supported by senior managers. Most staff described recent improvements in the last two months. Staff were positive about the ward refurbishments and how this had improved the environments for patients.
- Staff told us that they had opportunities for personal development however many staff had not had the opportunity to participate in specialist training.
- Some staff described positive team working across the multi-disciplinary team. We observed some collaborative working across professional groups in order to meet the patient's needs.

Commitment to quality improvement and innovation

- We were not assured that the overarching systems in place are sufficient to ensure that quality improvements are sustained. The CQC has had significant and ongoing concerns for this service. At the previous comprehensive inspection in 2015, the service was rate as inadequate. Some improvements were noted in a follow up inspection and they were rated as requires improvement. They have now slipped back substantially and the service has failed to sustain improvements in the quality of care and treatment provided to their patients.
- The provider had recently achieved AIMS accreditation for Elstow 3 ward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that ligature risk assessments are accurate and that they effectively mitigate risk where there are poor lines of sight.
- The provider must ensure that practices and documentation for seclusion are in line with the Mental Health Act Code of Practice.
- The provider must ensure that practices and reviews of long-term segregation are in line with the Mental Health Act Code of Practice.
- The provider must ensure there are sufficient staff on the wards with experience and skills to meet the patients' needs.
- The provider must ensure that patient observations are completed and that they maintain accurate records.
- The provider must ensure that all records and documentation relating to patients are stored securely.
- The provider must ensure that all staff complete mandatory training.
- The provider must ensure that all staff receive and document regular supervision.
- The provider must ensure that care plans are accurate; person centred, recovery focused, and capture the patients' views.
- The provider must ensure that care records document when staff support patients to make decisions.
- The provider must ensure that all staff treat all patients with dignity and respect.
- The provider must ensure that robust clinic room checks are completed and that equipment is in date.
- The provider must ensure that there are robust processes in place for the management of medication.
- The provider must ensure that all staff receives an annual appraisal.
- The provider must ensure that patients have access to appropriate psychological therapies.

Action the provider SHOULD take to improve

- The provider should ensure that staff have opportunity to attend non-mandatory training that will enhance understanding of the patient group and treatment needs.

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 • Care plans were not recovery focused or person centred. • Some care plans were inaccurate, out of date and did not identify the patients' needs. • Patient's views were not captured in care plans. • Staff were not supporting patients to improve their engagement in meaningful activities. • Staff were not documenting when they supported patients to make decisions. • There were limited psychological interventions taking place to enable recovery and rehabilitation. This was a breach of regulation 9 1(a)(b)(c) and 2 (b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Staff did not maintain patients' dignity at all times. • Not all staff were respectful in their interactions and communication with all patients. This was a breach of regulation 10, 1 and 2 (a)

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

This section is primarily information for the provider

Requirement notices

- Ligature risk assessments were not accurate; they did not identify all ligature points or include detailed mitigation to manage all risks.
- Patients were secluded in bedrooms not specifically designated for seclusion. These areas did not allow clear observation.
- Seclusion paperwork was not always complete or accurate.
- Long-term segregation reviews and documentation was not in line with the
- Mental Health Act Code of Practice
- Medicines management including storage, dispensing, and medicine reconciliation was not robust on all ward. There was out of date equipment in some clinic rooms.
- We found unlabelled patient only medication in clinics.
- Patient allergies were not accurately recorded.
- Effective observations were not always taking place.

This was a breach of regulation 12, (1) and (2) (d)(e) and (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • Patients were secluded in bedrooms not specifically designated for seclusion. This was a breach of regulation 15, 1(b) (c)

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

This section is primarily information for the provider

Requirement notices

- Managers did not ensure that all staff received supervision and appraisals.
- Managers did not ensure that all staff completed mandatory training.
- Managers did not ensure that practices around seclusion and long-term segregation were in line with the Mental Health Act Code of Practice.
- Managers did not ensure that staff completed observations on all patients.
- Seclusion paperwork did not document any discussion regarding moving patients to a more appropriate environment.

This was a breach of regulation 17, 1 and 2 (a)

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 • Staff had not received an appraisal. Compliance rate was 36%. • Bank staff compliance with mandatory training was low. • Not all permanent staff had completed all elements of mandatory training. • Bank staff were not receiving supervision in line with the provider's policy. • Staffing did not allow staff to observe all area of the wards at all times. • Wards did not always have the planned staffing establishment. • Staff were not completing the required observations at all times. We found gaps in observation records. This was a breach of regulation 18, 2 (a)