Cambian Fairview Hospital

Quality Report

Boxted Road
Mile End
Colchester
Essex CO4 5HF
Tel: 01206 848000
Website: www.cambiangroup.com

Date of inspection visit: 25 May 2016
Date of publication: 02/09/2016

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 summary

From our inspection we found:

- The provider's governance systems and processes for sharing learning from incidents with staff as part of risk management were not robust.
- Staff investigation reports were not detailed and information was lacking as to if action plans were completed to reduce further risks.
- Staff had not updated six patients' risk assessments, care plans and positive behaviour support plans to reflect a change in risk management following safeguarding incidents.
- We found incidences where staff had not adequately observed patients when they posed a risk to themselves or others.
- Staffing rotas were not always updated to reflect staffing levels.
- Management and leadership was not consistent as there were several changes to head of care posts who managed the wards. Three staff expressed concerns about the effectiveness of management support and the lack of feedback on issues raised.
- Staff meetings were not regularly taking place and minutes did not always detail how decisions were taken to evaluate and improve the service.
- Staff were not achieving mandatory training targets identified by the provider, for example relating to safeguarding adults.
- A staff member said they had not had restraint training and had been involved in restraint.
- We found examples where the provider's policies and procedures had not been improved to reflect current national guidance.

Summary of findings

- The provider had not improved their practice, responding to feedback from the CQC regarding notifications and providing updates in a timely manner.

However:

- Patients told us they felt safe on the ward living with others and were able to tell staff if they had any concerns.
- We saw good examples of positive staff and patient interaction and individual support.
- Staff knew how to report incidents and safeguarding concerns. Managers had systems for reporting and tracking safeguarding referrals to the local authority, police and CQC.
- Managers told us that they had identified problems with their governance systems and communication with staff. They had contacted the provider's quality team to improve processes.
- The provider had consulted the National Autistic Society to improve their service.

Summary of findings

Contents

Summary of this inspection

Background to Cambian Fairview Hospital

Cambian Fairview Hospital is an independent hospital providing specialist services for adults with learning disabilities who may also have other complex mental health problems, such as autistic spectrum disorder, and who may be detained under the Mental Health Act 1983.

The provider for this location is Cambian Learning Disabilities Limited and the corporate provider is Cambian Healthcare Limited.

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

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

This location is registered with the Care Quality Commission to provide the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

Simon Belfield is registered with the Care Quality Commission as the hospital manager. The hospital does not have an identified controlled drugs accountable officer. The provider has advised the CQC of their plans to submit an application for this.

The Care Quality Commission previously carried out a comprehensive inspection of this location from the 11th to 13th of August 2015. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for regulations 12 safe care and treatment, 17 good governance, 18 staffing, 15 premises and equipment.

A breach of CQC (Registration) Regulations 2009 was identified for regulation 18 regarding notifications. The provider sent the CQC their action plans to address these issues and we will check on this at a further inspection.

Our inspection team

Our inspection team was led by:

Team leader: Victoria Green, inspection manager, mental health hospitals.

Lead inspector: Kiran Williams, inspector, mental health hospitals.

The team included three CQC inspectors and an inspection manager.

Why we carried out this inspection

We carried out a focused inspection of this location in response to concerns identified by the Care Quality Commission relating to safeguarding reporting, investigation and management. The inspection focused on three domains, safe, caring and well led. The CQC focused the inspection on Cherry Court, Laurel Court and Larch Court wards.

Summary of this inspection

How we carried out this inspection

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

During the inspection visit, the inspection team:

- Visited Laurel Court and Cherry Court wards. Inspectors did not visit Larch Court, as staff told us patients were unsettled that day and our presence would affect them further.
- Spoke with three patients who were using the service.
- Attended a patients' forum meeting and met with two patient representatives.
- Spoke with nine staff members; including the deputy hospital director and clinical services director from the organisation's quality team.
- Reviewed care and treatment records relating to nine patients.
- Inspected a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Patients were positive about the support that they received on the ward.
- Patients told us they felt safe on the ward living with others and that they were able to tell staff if they had any concerns.
- Two patients said they did not get feedback on the actions taken by staff after raising concerns.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

From our inspection we found:

- Staff had not updated six patients' risk assessments, care plans and positive behaviour support plans following safeguarding incidents.
- We found three incidences where patients were not being adequately observed by staff and they posed a risk to themselves or others.
- Staffing rotas were not always updated to reflect staffing levels.
- Staff were not achieving mandatory training targets identified by the provider, for example relating to safeguarding adults.
- A staff member said they had not had restraint training and had been involved in restraint.

However:

- Patients told us they felt safe on the ward living with others and were able to tell staff if they had any concerns.
- Staff were aware of their individual responsibility in identifying any individual safeguarding concerns and reporting these promptly. Managers had systems for reporting and tracking safeguarding referrals to the local authority, police and CQC.
- The provider used nationally recognised assessments such as the short-term assessment of risk and treatability assessment tool as part of their initial and on-going assessment of risk.
- The provider was working towards reducing the use of restraint as recommended in the guidelines 'Positive and proactive care' produced by the Department of Health in 2014.

Are services caring?

From our inspection we found:

- Patients were positive about the support that they received on the ward. Where they had concerns, we found that staff had investigated or were investigating their complaints.
- We saw good examples of positive staff and patient interaction and individual support.
- Staff were passionate and enthusiastic about providing care to patients with complex needs.
- Patients had opportunities to get involved in hospital governance for example in the monthly patients' forum.
- Patients and a speech and language therapist were involved in a consultation to develop the hospital reception area to make it more patient centred and welcoming.

Summary of this inspection

However:

- Laurel Court community meeting minutes did not capture the actions taken by staff following a patient's request for community leave.

Are services well-led?

From our inspection we found:

- The provider had some governance processes to manage quality and safety but these were not robust.
- Investigation reports were not detailed and information was lacking as to if actions plans were completed to reduce further risks.
- The registered manager was on leave during the inspection. The covering manager did not have easy access to information and management records and governance systems.
- Changes to head of care posts who managed the wards affected consistent management and leadership.
- Three staff expressed concerns about the effectiveness of management support and the lack of feedback after reporting issues.
- Ward team meetings were not routinely taking place and information was not always communicated to staff from governance meetings.
- The provider's policies were not always up to date or detailed to reflect current national guidance which posed a risk that staff would not have relevant information to refer to in their work.
- The provider had not improved their practice responding to feedback from the CQC regarding notifications and providing updates in a timely manner.

However:

- Managers told us that they had identified problems with their governance systems and communication with staff. They had liaised with the provider's quality team to improve processes.
- A quality audit for Laurel and Cherry Court wards had taken place with staff from the organisation external to the hospital to give an objective opinion.
- The provider had consulted the National Autistic Society to improve their service.
- Staff were aware of whistleblowing processes and information was available for reference.

Wards for people with learning disabilities or autism

Safe	
Caring	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe staffing

- The provider was using a tool they had developed to determine basic staffing levels based on patient occupancy.
- Two staff and one patient said there were not enough staff.
- Staffing rotas from the provider for April and May 2016 showed Cherry Court and Laurel Court as not having qualified nurse on shift for five occasions and Larch Court on one occasion. Staffing rotas seen were difficult to read and judge if staffing levels were met. The provider stated that rotas would not accurately reflect staffing levels as if a ward was short staffed, the wards, which had additional staff, would transfer staff across to give support.
- The provider used regular bank and agency staff. For the week commencing 16/05/2016 the provider's records showed, 76% were permanently employed staff, 20% were bank staff (employed by the provider for on an as and when required basis) and 4% were external agency staff. The highest use of non-permanent staff was the week of 04/04/2016 where there was 73% permanent, 22% bank and 5% agency staffing used.
- Managers told us that where possible they used regular agency and bank staff to ensure consistency of approach and because some patients had difficulty managing change and meeting new staff.
- Staff team meeting minutes 29/02/2016 showed that staff overall mandatory training attendance was 75% with a requirement to reach 90% by 07/03/2016.

Assessing and managing risk to patients and staff

- Patients told us they felt safe on the ward living with others and were able to tell staff if they had any concerns.
- Managers had systems for reporting and tracking safeguarding referrals to the local authority, police and CQC.
- Recent meetings with the local police and local authority had taken place to improve reporting and exchange of information. We saw some systems to report incidents via local procedures. During our visit, a representative from the local authority safeguarding team met with managers to review the safeguarding reporting, investigation and feedback process.
- Staff said they had safeguarding training. Staff were aware of their individual responsibility in identifying any individual safeguarding concerns and reporting these promptly.
- Information from the provider showed that not all staff were up to date with mandatory safeguarding training. For example, the lowest compliance was Larch Court staff with 25%. The highest was Redwood Court with 84% compliance. Other wards showed 60% staff compliance or less. This posed a risk that staff would not have up to date information to refer to in their role to safeguard patients.
- The providers local safeguarding policy dated January 2016 referred to a 'safeguarding plan'. However, managers said that patients did not specifically have these. They said instead that risk assessments, care plans and positive behaviour support (PBS) plans would be updated to reflect the risks. However, actions taken by staff after incidents to safeguard and protect patients were not always detailed in patients' records.
- Patients had individualised risk assessments completed by the multi-disciplinary team. The provider used nationally recognised assessments such as the short-term assessment of risk and treatability (START) assessment tool as part of their initial and on-going assessment of risk.
- Staff had completed the historical clinical risk (HCR 20) assessment for patients identified at high risk of violence. For one patient a functional analysis of their behaviour was taking place.
- Ward review documentation showed staff referred to the use of 'ABC', antecedent, behaviour, consequence charts

to identify possible triggers to behaviours following patient incidents. Larch Court staff had received specific training in February 2016 to manage a patient's challenging behaviour.

- However, staff had not updated six patients' risk assessments, care plans and PBS plans following safeguarding incidents. This presented a risk that staff did not have up to date information to refer to when delivering care and treatment.
- Staff completed daily risk assessments for patients with a red, amber, green (RAG) traffic light system to different risk levels. However, staff had not updated two patients daily risk management plans on Larch and Cherry court wards following a change in risk.
- Staff we spoke with had a good understanding of observations and their duties when closely supporting patients. However, we found examples where staffing observation was lacking. One patient on Cherry Court required two staff escorts with them because of the risk of harm to themselves. However an incident form showed they were left alone unobserved 01/05/2016 in the community and they self-harmed. There were no details of how the provider had reviewed this incident and if staff took actions to reduce the risk of reoccurrence. Care records for a Laurel Court patient did not detail why their observation levels were different at night and daytime.
- Staff told us that they checked patients daily for any injuries or marks and they documented these on a body map. Forms seen showed staff completed these monthly for patients. A Larch Court patient was last checked 03/05/2016 indicating that staff had not increased their checks despite the patient having unexplained injuries whilst on constant staff observation.
- The provider was working towards reducing the use of restraint as recommended in the guidelines 'Positive and proactive care' produced by the Department of Health in 2014. Clinical governance meeting minutes 29/02/2016 showed Redwood Court had the highest amount of restraints, 30 in January and Larch Court, 34 in February 2016. Laurel Court had the least in January with zero and three in February 2016.
- Incident forms available showed staff had used restraint when necessary. Staff told us this was for the least time possible and did not use prone restraint (prone restraint is where staff hold a patient face down) and the focus was on verbal de-escalation techniques rather than restraint whenever possible. Where rapid tranquilisation had taken place, we saw staff had monitored patients' physical health.
- Updated MAPA (management of actual or potential aggression) foundation programme training data from the provider for May 2016 showed that 100% of staff had received training across wards expect Elm Court which had 89%. There were no other details of the staff restraint training. A staff member said they had not had restraint training and had been involved in restraint. However the provider later stated that the staff member had received previous restraint intervention training but had not completed the current training.

Reporting incidents and learning from when things go wrong

- The provider had a system for incident reporting. However, governance systems and records for sharing learning from incidents with staff were not robust. Managers acknowledged their systems did not fully capture the work they were doing and that they needed to improve their communication with staff.
- Staff reported incidents via paper incident reporting forms. All but one staff knew how to report incidents and were encouraged to use the reporting system. The paper incident recording forms had space for documenting learning of lessons but those reviewed were not completed. A manager acknowledged this. We saw examples where staff had completed incident forms and the provider had sent a statutory notification to the CQC. However two incident forms on 09/05/2016 for Laurel Court were inaccurate. During our visit, a patient raised a safeguarding concern and staff reported the concern to the local authority.
- Staff told us that incidents would be discussed at staff meetings or in ward handovers and learning identified. Staff said that they and patients had access to debriefs and support following incidents and we saw examples of this on Larch Court for April and May 2016, with actions identified. However, there was no information if these actions were completed.
- Two staff said that staff received feedback from incidents at the time of the event. Two patients said they did not get feedback on the actions taken by staff after raising concerns.

Wards for people with learning disabilities or autism

- Staff said they did not always receive feedback relating to learning from incidents and any actions taken to reduce the risk of reoccurrence. A staff member gave an example of learning and said staff had updated the patient's records following an incident. However, whilst an electronic record was available there was none in the main paper file for staff and the patient to easily access and refer to.
- The provider had recently started a twice weekly 'incident review and lessons learned meetings' where senior staff met to discuss and review incidents and complaints. The provider sent us their meeting agenda. Staff had not taken meeting minutes detailing discussions and actions required to reduce reoccurrence for staff reference. Staff acknowledged this and said they would be completed in the future.
- Clinical governance meeting minutes gave details on the number of incidents. For example, for February 2016, Larch Court had the highest amount with 61 patient incidents. It has four beds and managers said all patients were on 2:1 staffing observations. Staff had identified Redwood Court as having an increase in incidents from November 2015 to January 2016 with 23 increasing to 43. In November 2015 the hospital had 82 open safeguarding alerts. However, meeting minutes did not show actions taken for risk areas and any learning from incidents.
- The provider's safeguarding incident investigation process was not robust. Two safeguarding incident investigation reports seen did not fully detail the investigative process and the rationale for actions identified to reduce the risk of reoccurrence. Two managers said that they were reviewing their incident investigation process. The provider stated that staff investigation training was commissioned for 08/06/2016 to improve the quality of investigations, which included elements of root cause analysis (care and service delivery problems). Records did not state that following a safeguarding investigation for one Larch Court patient, if the action plan was completed. A manager said they believed the action plan had been actioned but would confirm this with us. The CQC did not receive further confirmation of this.

Are wards for people with learning disabilities or autism caring?

Kindness, dignity, respect and support

- Patients were positive about the support that they received on the ward. Where they had concerns, we found that staff had investigated or were investigating their complaints.
- During our visit, one patient told us they had made a complaint to the provider and CQC and a manager told us they would take action to address this.
- We saw good examples of positive staff and patient interaction and individual support. For example, staff took time to give information to patients who had difficulty speaking or communicating non-verbally.
- Staff were passionate and enthusiastic about providing care to patients with complex needs. Cherry Court staff meeting minutes 13/01/2016 referred to managers holding 'micro' teaching sessions to raise awareness of national nursing guidance 'compassion in care' and the six 'c's: 'care, compassion, competence, communication, courage and commitment'.

The involvement of people in the care they receive

- We found some examples of how patients or their advocates were involved in influencing their care and treatment or of the service at the hospital. For example, signing their care plan after completion and being involved in development of easy read care planning documents. However, staff had updated a Cherry Court patient's care plan but not involved the patient in the development.
- Patients had opportunities to get involved in hospital governance, for example, in the monthly patients' forum. A manager said staff were making changes to ensure it was a more person centred with advocacy supporting patients to chair and lead the meetings.
- Patients attended community meetings on the wards and minutes showed patients were able to raise concerns with staff taking actions. However, Laurel Court community meeting minutes for three months showed a patient had requested a community leave trip and staff had twice stated it was not possible to arrange leave, particularly at weekends without a clear

explanation.The provider stated this related to a complex issue and acknowledged that the records did not fully capture this. They stated that they would take action to address this.
- Patients had access to advocacy services and information regarding these services was displayed across wards. This included access to independent mental health and independent mental capacity advocates.
- Patients and a speech and language therapist were involved in a consultation to develop the hospital reception area to make it more patient centred and welcoming.

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

Good governance

- The provider had some governance processes to manage quality and safety but these were not robust.
- Managers told us that they had identified problems with their governance systems and communication with staff. They were liaising with the provider's quality team to improve processes. The provider had developed an action plan following the last CQC inspection in August 2015 and they were further reviewing this.
- The provider had meetings with the local police and local safeguarding team to improve the reporting of incidents, information sharing and investigation processes. In April 2016 the CQC, local police and local authority safeguarding team had given feedback to the provider of the need to improve the quality of information given when reporting incidents. Managers told us of the actions they would take to include a more thorough quality assurance checking mechanism. However, the CQC later received notifications that were inaccurate 19/05/2016 for Redwood Court and 09/05/2016 Laurel Court showing the revised quality assurance system was not effective.
- The provider did not provide some further information in a timely manner requested by the CQC relating to a notification 30/04/2016, where requests were made in writing and verbally.
- The hospital had a designated safeguarding lead in line with the provider's policy and a process for auditing safeguarding processes. However, the lead was the registered manager who was on leave during the inspection. The covering manager did not have easy access to information and management records to show us the governance systems for safeguarding.
- There were gaps in patients' risk assessments, care plans, safeguarding and incident investigation records showing that the provider's quality assurance systems for monitoring this were not robust. Staff did not always document actions following a review of incidents and learning. Therefore, we were not assured that the provider was taking action to reduce risks relating to the health, safety and welfare of patients and others.
- Minutes from staff meetings available did not demonstrate how learning from incidents was shared with staff following investigation. This posed a risk that staff would not know what actions they should take to reduce risk of reoccurrence. The last hospital clinical governance meeting minutes showed standard headings for discussion of safeguarding, incidents and risk management. The provider had standard agenda headings to track staffing risks and data where activities were cancelled. However, minutes held limited information.
- We asked for staff team meeting minutes and managers said that ward team meetings were not routinely taking place, which they were taking action to address. The last Cherry Court meeting was 13/01/2016; staff were typing up Laurel Court meeting minutes from April 2016. Larch Court had not had any formal staff team meetings in 2016.
- A manager said they had identified issues for Laurel and Cherry Courts and a quality audit had taken place with staff from the organisation, external to the hospital. The provider later sent the CQC a copy of this which included actions to be taken to improve sharing of lessons learnt following investigation and identifying themes and trends.
- The provider's policies were not always up to date or detailed which posed a risk that staff would not have relevant information to refer to in their work. For example, the provider sent us three versions of their 'policy and procedure on serious incidents'. Two were dated August 2013 and 2014. The provider gave the CQC a further drafted policy, which referred to 2015 national guidance but was not in operation for staff use. This policy referred to learning of lessons shared via the clinical governance structures. The organisational and

hospital local safeguarding policies dated 2016 did not detail the governance systems in place for overseeing and monitoring of safeguarding incidents and sharing learning from investigations.

Leadership, morale and staff engagement

- There was a lack of consistent management and leadership. There had been a change in the hospital's management structure since August 2015. In addition to the hospital director and deputy director roles, two heads of care had been appointed and then dismissed. The provider changed the management structure following staff consultation to have three heads of care that had oversight of the wards. At our inspection, managers told us there had been a further change to this as one head of care had changed. A staff member told us that they had only received supervision once in nine months. We saw there were systems to arrange staff supervision and monitor compliance for example on Larch Court.
- There were out of hours on call rotas for managers and doctors who staff could contact to discuss issues.
- Staff were aware of whistleblowing processes and information was available for reference. Most staff we spoke with said morale was good. Staff said they were able to talk to their managers and give feedback on the service.
- However, three staff expressed concerns about the effectiveness of management support and feedback on issues. Two staff expressed concerns about the potential for repercussion from managers about raising issues.

Commitment to quality improvement and innovation

- The provider had liaised with the National Autistic Society regarding accreditation standards for residential settings. Whilst the location was a hospital, managers considered this contact would be useful to improve the service they gave for patients with autism. A visit to Larch, Elm and Redwood Court wards had taken place 20/05/2016 with some initial feedback.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are robust systems and processes established and operated effectively to prevent abuse of patients, to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
- The provider must ensure there are governance systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk of the services provided.
- The provider must ensure there are governance systems to ensure accurate records in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided.
- The provider must ensure there are robust governance systems to show evaluation and improvement of their practice.
- The provider must ensure that all staff receive restraint training before working on the units.

Action the provider SHOULD take to improve

- The provider should ensure that staff rotas are accurate and hold sufficient information to reflect how they are ensuring adequate staffing for patient occupancy and need.
- The provider should ensure that staff are compliant with mandatory training targets identified by the provider.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider must ensure there are robust systems and processes established and operated effectively to prevent abuse of patients, to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. The provider must ensure that all staff receive restraint training before working on the units. This was a breach of Regulation 13(1) (2) (3), The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure there are governance systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk of the services provided. The provider must ensure there are governance systems to ensure accurate records in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided. The provider must ensure there are robust governance systems to show evaluation and improvement of their practice. This was a breach of Regulation 17(1) (2) (a) (b) (c) (f), The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.