Rohan

Quality Report

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

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

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

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

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

Overall summary

We found the following concerns that the service provider needed to improve:

- Patients' living environments contained some ligature points that had not been identified on environmental risk assessments.
- Staff were unable to observe or have two-way communication with patients during episodes of seclusion. This meant staff could not effectively respond to physical health emergencies or incidents of self-harm or accidental injury.
- Staff did not provide patients with ongoing physical health monitoring as identified in their care plans.
- Patients were not currently registered with a GP. This meant they did not have access to NHS health checks, referrals to specialist physical care or regular review of existing physical health medicine. The service had proactively tried to address this without success.
- The service did not utilise input from a clinical psychologist to analyse data on patients' behaviour and review support plans. However, this had been discussed at a recent multidisciplinary meeting and plans were in place to increase psychological input in this area.

Summary of findings

- The service made decisions in patients' best interests and had systems in place to ensure their finances were managed effectively. However, the documentation surrounding these areas needed to be formalised to safeguard patients and staff.

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

- Patients were supported in spacious and clean environments by sufficient staffing that ensured their safety.
- Following our comprehensive inspection in November 2015, the service had introduced staff training in the use of the defibrillator. The majority of staff had received this training with additional sessions planned.
- Patients had comprehensive risk assessments that allowed them to safely participate in a range of activities in the hospital and community.
- Staff implemented plans that supported patients in the least restrictive way. At the time of the inspection both patients were not in need of restraint following episodes of aggressive or challenging behaviour.
- Following our comprehensive inspection in November 2015, the service had implemented a contract with a local pharmacy to provide regular audits of medicine management.
- Patients had positive behaviour support plans, care plans and risk management plans that were person centred, detailed and correlated with other plans.
- Following our comprehensive inspection in November 2015, the service had increased their participation in clinical audits in areas such as incident reporting, quality of staff debriefs after incidents and the Mental Health Act.
- The service was well supported by the local learning disability community team. This ensured the patients had access to occupational therapists and speech and language therapists.
- The service had responded positively to findings from a Mental Health Act reviewer visit in February 2017. Patients had been seen by an independent mental health advocate and an action plan had been produced to address gaps in Mental Health Act paperwork.
- Following our comprehensive inspection in November 2015, the service had been collecting feedback from patients and carers via surveys and increased phone calls.
- The provider had comprehensively assessed one patient's care and support needs for living in the community. This was in line with the Transforming Care agenda which is committed to moving people with learning disabilities and autism out of hospital settings into the community.
- Following our inspection in November 2015, the service had been submitting data to the Mental Health and Learning Disability Data Set.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism		Start here...

Summary of findings

Contents

Rohan

Services we looked at

Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Rohan

Rohan provides care and treatment for two male patients who have learning disabilities or autism and challenging behaviours. At the time of our inspection, both patients were detained under the Mental Health Act. Rohan is a bespoke service and supports each patient in an individual self-contained flat, both of which are located on the ground floor.

Rohan is registered to provide the regulated activities: treatment of disease disorder or injury; assessment or medical treatment for persons detained under the Mental Health Act 1983; and diagnostic and screening procedures.

Rohan has a registered manager.

Rohan was managed by Turning Point, who took over the provision in September 2013. The Care Quality Commission carried out a comprehensive inspection of the service in November 2015 and rated it good in the domains of safe, effective, caring, responsive and well-led. This resulted in the service being rated as good overall and there were no breaches of regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014.

Our inspection team

The team that inspected the service comprised two CQC inspectors, a nurse who specialised in learning disability and a Mental Health Act reviewer.

Why we carried out this inspection

We undertook this unannounced focused inspection due to a Mental Health Act reviewer raising concerns following a visit on 28 February 2017. The reviewer found that:

- there was no independent mental health advocate (IMHA) service being commissioned by the provider;
- there was some Mental Health Act paperwork unavailable for review and some existing paperwork contained minor errors;
- neither patient was currently registered with a general practitioner and both had physical health needs that required on going monitoring;
- both patients had treatment plans that, when implemented, meant they were meeting the criteria for being secluded as defined by The Mental Health Act Code of Practice. The provider was reporting these episodes as seclusion, however, certain requirements, such as being able to maintain observation of the patients, were not being met.

We also looked at the following areas that had been identified as areas the service should make improvements following our comprehensive inspection of the service in November 2015.

- The provider should review staff training to include the use of a defibrillator.
- The provider should review their medication audits and lack of pharmacy input and support.
- The provider should review their arrangements for medical cover to ensure that when the doctor is on annual leave or sickness access to another doctor is available if needed.
- The provider should consider appropriate training for all staff in the use of the Mental Health Act.
- The provider should review how they seek feedback from patients and relatives/carers.
- The provider should review medication certificates. Best practice would be to renew T2 certificates at 12 monthly intervals and T3 certificates at 24 monthly intervals.

Summary of this inspection

- The provider should review their lack of participation in clinical audits, particularly with regard to the green light toolkit.
- The provider should ensure that they submit data to the Mental Health and Learning Disability Data Set and Mental Health Services Data Set.

As this was not a comprehensive inspection we did not pursue all of our key lines of enquiry. Therefore, this report does not indicate an overall judgement of the service. Our resources were directed towards inspecting the current areas of potential concern and this should be considered when reading the report.

How we carried out this inspection

During this focussed inspection we considered areas of the service to make a judgement on the following questions:

- 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 a Mental Health Act reviewer report and information that we held about the service through our intelligent monitoring processes.

During the inspection visit, the inspection team:

- visited both patient's self-contained flats and looked at the quality of the environments;
- carried out a short observation of how staff were supporting one patient;
- spoke with the registered manager;
- spoke with seven other staff members; including a doctor, a nurse, a psychologist and support workers;
- spoke with two carers of people who used the service;
- attended and observed one hand-over meeting;
- looked at two care and treatment records of patients:
- carried out a focussed check of the medication management;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with the parent of one patient. They told us they speak to their son twice a week by phone and see them in person approximately once every six weeks, alternatively at the hospital and at their home address. They felt the service has been very proactive in accommodating their son's preferred activities, such as swimming and horse riding. They found the service very responsive when they made contact and had regular updates about changes in care or treatment. They informed us how a historic staffing incident had been appropriately addressed.

They told us they regularly attend meetings and felt involved in all aspects of the patient's care. They positively referred to how the service had involved them in an end of life plan. They received regular updates by phone and were notified by phone when decisions were being made in the patient's best interests and financial issues.

Both spoke highly of staff and felt they treated patients with compassion, dignity and respect. Both felt that patients' quality of life had been enhanced by the service. Both were unaware that patients were not currently registered with a GP.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues that the service provider needed to improve:

- Patients' living environments contained some ligature points that had not been identified on environmental risk assessments.
- Staff were unable to observe or have two-way communication with patients during episodes of seclusion. This meant staff could not effectively respond to physical health emergencies or incidents of deliberate or accidental injury.

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

- Patients were supported in spacious and clean environments by sufficient staffing that ensured their safety under normal circumstances.
- Following our comprehensive inspection in November 2015, the service had introduced staff training in the use of the defibrillator. The majority of staff had received this training with additional sessions planned.
- Patients had comprehensive risk assessments that allowed them to safely participate in a range of activities in the hospital and community.
- Staff implemented plans that supported patients in the least restrictive way. Both patients did not currently need to be restrained following episodes of aggressive or challenging behaviour.
- Following our comprehensive inspection in November 2015, the service had a contract with a local pharmacy to provide regular audits of medicine management.

Are services effective?

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

- Staff were not always providing patients with ongoing physical health monitoring as identified in their care plans.
- Patients were not currently registered with a GP. This meant they did not have access to NHS health checks, referrals to specialist physical care or regular review of existing physical health medicine. The service had proactively tried to address this issue without success.

Summary of this inspection

- The service did not utilise input from a clinical psychologist to analyse data on patients' behaviour and review support plans. However, this had been discussed at a recent multidisciplinary meeting and plans were in place to increase psychological input in this area.
- The service made decisions in patients' best interests and had systems in place to ensure their finances were managed effectively. However, the documentation surrounding these areas needed to be formalised to safeguard patients and staff.

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

- Patients had positive behaviour support plans, care plans and risk management plans that were person centred, detailed and correlated with other plans.
- Following our comprehensive inspection in November 2015, the service had increased their participation in clinical audits in areas such as incident reporting, quality of staff debriefs after incidents and The Mental Health Act.
- The service was well supported by the local learning disability community team. This ensured the patients had access to occupational therapists and speech and language therapists.
- The service had responded positively to findings from a Mental Health Act reviewer visit in February 2017. Patients had been seen by an independent mental health advocate and an action plan had been produced to address gaps in Mental Health Act paperwork.

Are services caring?

We found the following areas of good practice:

- Following our comprehensive inspection in November 2015, the service had been collecting feedback from patients and carers via surveys and increased phone calls.

Are services responsive?

We found the following areas of good practice:

- The provider had comprehensively assessed one patient's care and support needs for living in the community. This was in line with the Transforming Care agenda which is committed to moving people with learning disabilities and autism out of hospital settings into the community.

Are services well-led?

We found the following areas of good practice:

Summary of this inspection

- Following our inspection in November 2015, the service had been submitting data to the Mental Health and Learning Disability Data Set.

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.

- During the comprehensive inspection in November 2015, we told the provider they should consider appropriate training for all staff in the use of the Mental Health Act. During this inspection we found some improvement had been made in this area. The provider's Mental Health Act administrator had delivered two sessions of Mental Health Act training to 14 members of staff. Staff we spoke with had a good understanding of parts of the Act that were relevant to their work, for example, the recording of patients taking leave from the hospital and the requirements of ensuring patients, or their nearest relatives, were aware of their rights under the Act.
- During the comprehensive inspection in November 2015, we told the provider they should review medication certificates and highlighted that best practice would be to renew T2 certificates at 12 monthly intervals and T3 certificates at 24 monthly intervals. These forms allow medical professionals to prescribe medicine to people detained under The Mental Health Act and indicate whether or not the patient has capacity to understand the nature of the treatment. During this inspection we found that one patient's current T3 certificate was dated 2010 and had been completed when they were in a previous placement. The hospital manager told us they had raised this issue with medical professionals and the Care Quality Commission but a new T3 certificate had not been completed as The Mental Health Act Code of Practice does not define a time scale for renewing these forms.
- Following the Mental Health Act reviewer visit in February 2017, both patients were visited by an independent mental health advocate (IMHA). The hospital manager told us the IMHA had found no issues that required their input currently.
- During the Mental Health Act reviewer visit in February 2017, it was found that some Mental Health Act paperwork was not available on site. We saw an action plan that showed the provider had acknowledged this and was in the process of addressing this issue.
- Both patients had received a Mental Health Act Tribunal review in January 2017. This is a court process where the appropriateness of the detention is scrutinised to ensure that continued detention is required and that the patient is received appropriate treatment. We saw positive feedback from the tribunal in regards to overall care, quality of progress notes and implementation of treatment plans.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed best interest decision forms following appropriate assessments of patient's capacity. We saw that staff had decided that one patient's kitchen door should be kept locked due to recent behaviour being identified as a risk. This had been documented correctly.
- The service did not arrange formal best interest meetings. However, we spoke with a parent and nearest relative who both confirmed they were contacted regularly to gain their views on financial issues, such as informing them of the service's intention to take the patients on trips or buy them things.
- The hospital manager was the appointee for both patients. This allowed them access to their finances. They told us this role had been transferred to them from the previous manager. The service had a robust system in place that audited monies spent against quarterly bank statements. We discussed how the appointee role may benefit in being formalised and included in care plans to ensure transparency and safeguard all involved. The hospital manager agreed to discuss this with their line manager.

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- The service supported each patient in a ground floor self-contained flat. They were spacious and provided a lounge, dining area, bedroom, bathroom and garden. The layouts presented some restricted lines of sight but these were effectively mitigated through three staff being present.
- The service carried out a number of comprehensive environmental risk assessments to ensure both patients were supported in safe environments. However, we found that internal doors had hinges that could potentially be used to attach a ligature to assist self-harm and these had not been identified on a risk assessment. The hospital manager told us that both patients had low risk of engaging in this behaviour but agreed to address this issue.
- During the comprehensive inspection in November 2015, we told the provider they should review staff training to include the use of a defibrillator. During this inspection we found that face to face training in immediate life support had taken place seven times over the last year. This included training in use of the defibrillator. Currently 19 out of 29 staff had undertaken this training with more training sessions booked for the next month. Staff rotas confirmed at least one trained staff was on duty at all times.

Safe staffing

- The service had 29 permanent members of staff which included six that worked part time hours. This comprised of three full time nurses, five full time team leaders, 15 full time support workers and six part time support workers. The service currently had one nurse and one team leader on long term sick leave. There were currently two vacancies for nurses and five vacancies for support workers. The service had an ongoing recruitment process and a successful interview for a support worker took place during our inspection.
- The service supported each patient with three staff during the day and two staff during the night. There were no qualified nurses available during the night. The service had adopted an on call rota of nursing staff who were available to support night staff. We looked at the on call log book and saw the on call nurse had been contacted four times in the period between 1 January 2017 and 31 May 2017. Staff recorded nature of concern, actions taken and whether nurse had attended the hospital. The service had an on call policy which gave clear guidance to night staff in what situations they should access nurse support. We had previously received a notification from the service that showed an example of how they had appropriately managed a situation when the on call nurse had not followed the policy.
- We reviewed the staff rota for the previous four weeks and found that six shifts had been short by one member of staff. We saw that both patients had support plans that outlined how they could be supported by two staff if required. The hospital manager told us that, in these circumstances, a decision would be made to allocate staff appropriately dependent on both patients recent behaviour.
- The service was using seven agency staff at the time of the inspection. This comprised two nurses and five support workers. Six of these staff had been working regularly at the service for the three months prior to the inspection. One agency nurse had just started and was working additional to normal staffing levels to allow them to become familiar with the patient and their care plans.

- During the comprehensive inspection in November 2015, we told the provider they should review their arrangements for medical cover to ensure that, when the responsible clinician was on annual leave or sickness, access to another doctor was available if needed. During this inspection the provider and responsible clinician were able to confirm that their contract obliged them to source their own medical cover. The contract also permitted the provider to source medical cover from within their organisation when required.

Assessing and managing risk to patients and staff

- Both patients had comprehensive risk assessments that covered a range of activities within their flats and whilst accessing the community. Staff we spoke with had worked with the patients for a long time and showed a good knowledge of potential risks and how they were best managed.
- At the time of the inspection the service did not restrain either patient following episodes of aggressive behaviour. Two years ago the service had input from an external agency who specialised in supporting challenging behaviour. Following this input, both patients had support plans, called reactive withdrawal plans, that allowed staff to remove themselves from patients' flats when aggressive behaviour was becoming apparent. The support plans did not include rationale why they were less restrictive than other methods of managing challenging behaviour, such as restraining or administering medicine.
- Staff secluded patients on all occasions when they implemented the reactive withdrawal plan. These were recorded as incidents on the provider's incident reporting system. We viewed figures for episodes of recorded seclusion between 1 December 2016 and 30 April 2017 and found 201 and 380 episodes of seclusion for each patient respectively. Each period of seclusion was reviewed after 15 minutes and a decision was made if it needed to be extended for a further 15 minutes. We reviewed episodes of seclusion for one patient during May 2017 and found one instance where the seclusion period lasted 75 minutes. On that occasion staff had contacted the responsible clinician by phone who had authorised that extended period and had advised the patient be given pain relief medicine, as staff indicated that pain may be causing the behaviour.
- Staff also implemented support plans for both patients called proactive withdrawal plans. The objective of these was to give both patients time to themselves when it was felt clinically appropriate. Staff would communicate this intention with the patients to ensure they agreed with the plan for the staff to proactively withdraw. Staff told us this was often used when the patients had returned from being in the community as they benefitted from time on their own. However, during proactive withdrawal the patients were still left alone in a locked environment so met the criteria for seclusion. Staff recorded episodes of proactive withdrawal in the patients' progress notes but not on the provider's incident reporting system. We reviewed recent progress notes for episodes of proactive withdrawal and found it occurred, on average, six times a day. Furthermore, we reviewed 14 recent staff debrief forms, which were completed after episodes of reactive withdrawal, and found that three incidents of challenging behaviour had occurred after initially implementing proactive withdrawal.
- During periods of seclusion, staff did not have clear observation of patients or have clear two way communication with patients. These are requirements that the Mental Health Act Code of Practice state should be in place during periods of seclusion. The multidisciplinary team had considered this issue and concluded that monitoring of this type would heighten agitation and prolong periods of unsettled behaviour. Staff were reliant on a baby monitor for one patient, and standing in the adjoining kitchen, for the other patient, to give them an indication of their current mood and behaviour. This meant that staff were unable to fully monitor whether patients were at risk due to physical health issues or deliberate or accidental injury. During reactive withdrawal for one patient, the kitchen door was locked to minimalise the risk of deliberate or accidental injury. Staff told us they would engage with the patient through the locked door, at regular intervals, to ascertain whether it was appropriate for them to return. However, during our inspection, we saw that the patients would sometimes bang on the door to get staffs' attention.
- The service had a seclusion policy for one patient that guided staff on how to record seclusion and in what instances they needed to seek advice from the responsible clinician. The hospital manager recognised

that the seclusion policy required updating as the responsible clinician's work circumstances had changed since it was written and was now not as available to attend the service in person. We saw that following the Mental Health Act reviewer visit in February 2017 the multidisciplinary team (MDT) discussed this issue in their next meeting. Following this inspection the hospital manager provided us with redrafted seclusion policies for both patients. These accurately described the provision of medical cover and the expectations of qualified staff to ensure episodes of seclusion were reviewed appropriately.

- During the comprehensive inspection in November 2015, we told the provider they should review their medication audits and lack of pharmacy input and support. During this inspection we found the service was supported by a local pharmacy who completed a comprehensive audit of their medicine management on a yearly basis. We viewed the current audit from March 2017 and saw the service had acted on recommendations outlined in the audit. The only exception to this was the service had not completed a risk assessment for the use of a paraffin based cream that had been prescribed for one of the patients. The local pharmacy service also provided an advice line as part of the service.

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

Assessment of needs and planning of care

- The service had completed physical health assessments on both patients which identified historic and current physical health issues. However, we found that ongoing physical health monitoring was not happening consistently. One patient suffered from high blood pressure but was not having this monitored as directed in their care plan. Furthermore, staff were following a care plan to weigh this patient monthly. However, they were not recording it in a way that enabled them to identify any weight increase. We spoke with staff and this patient's parent who both recognised that their weight had increased over the last few months.
- We reviewed both patients' support plans and found they covered all areas of care delivered. Some support plans that were not implemented regularly had not been reviewed or discontinued. However, we found that positive behaviour support plans, care plans and risk management plans were person centred, detailed and correlated with other plans.

Best practice in treatment and care

- The service did not currently have access to a GP service for both patients. The previous GP had discharged both patients in August 2016 on the understanding that the service was a hospital and primary care needs should be met by the responsible clinician. The hospital manager recognised that not having the patients registered with a GP had a negative impact on their well-being and access to primary care. They told us they had not been able to make referrals for gastric and neurological investigation for one of the patients as these had to be initiated by a GP. They also recognised that both patients would benefit from an NHS health check as they were both over 40. The responsible clinician also raised concerns over the lack of GP as both patients were on physical health medicine that would benefit from being reviewed. They were only permitted to continue prescribing existing physical health medicine and could not initiate medicine or increase or decrease existing medicine. The service had been actively trying to get both patients registered with an alternative GP and had raised the issue with NHS England and their local Clinical Commissioning Group. More recently they had raised the lack of GP service as a safeguarding issue.
- The responsible clinician was currently acquiring medicine from the local pharmacy through an unconventional process. They listed medicines prescribed on letter headed paper and signed them off with their name and professional registration. They had initially met with the lead pharmacist to discuss and agree this method. They told us they had applied to NHS England to be able to prescribe medicine through FP10s in the future. This is the standard way that doctors prescribe medicines for collection at pharmacies.
- Staff completed a behavioural monitoring form after every incident. These captured the specific behaviours

displayed in relation to the situation and the resulting actions by staff. The hospital manager produced graphs of this data to allow the multidisciplinary team to identify themes.

- The service was supported by a clinical psychologist and psychology assistant. We saw minutes from a recent multidisciplinary meeting where the clinical psychologist had expressed they would like more involvement in the review of support plans and analysis of data that the service collected on patients' behaviour. We spoke with them and they felt they had been listened to and this had led to recent meetings with staff to gain an understanding of the challenges they face in implementing the support plans.
- Both patients had support plans that promoted and encouraged healthy eating. One patient had an eight week meal rota. Staff recorded food intake in a diary that had been introduced to monitor the patient's gastric pain. The diary contained a varied diet of the patient's preferred foods. Staff had been instructed to decrease sweets and carbohydrates and this had led to a reduction in the need to administer pain relief over the last three months. Staff who supported the other patient told us they found it more challenging encouraging healthy eating and felt the team could be more consistent with their approach to this issue.
- During the comprehensive inspection in November 2015, we told the provider they should review their lack of participation in clinical audits, particularly with regard to the green light toolkit which is a guide to auditing and improving services for people with autism and learning disabilities. During this inspection we saw some improvements in this area and found the service was completing clinical audits around medicine management, incident reporting, staff debriefs after incidents and The Mental Health Act. However, the service was not using the green light toolkit as guidance for their programme of clinical audits. The hospital manager informed us that the green light toolkit had been discussed and considered by the multidisciplinary team who had felt it did not meet the needs of their service model.

Multi-disciplinary and inter-agency team work

- The service had multidisciplinary meetings every six weeks that were attended by the hospital manager, responsible clinician, clinical psychologist and a learning disability nurse from the local community team. We viewed minutes from the three previous meetings and saw that each clinician gave updates on both patients' ongoing care. The responsible clinician and clinical psychologist did not have day to day input into the service but were available by phone to give sufficient advice and support.
- The service had a good working relationship with the local learning disability community team. They were represented at multidisciplinary team meetings and provided services such as occupational therapy and speech and language therapy. We saw that speech and language had been involved in assessing one patients risk whilst swallowing food and supporting the other patient to produce a 'life story' which is a document that supported them communicating their likes and dislikes. The service had recently accessed an occupational therapist to assess one patient's vehicle harness. This had led to an improved one being identified and was currently on order.

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

- During the comprehensive inspection in November 2015, we told the provider they should consider appropriate training for all staff in the use of the Mental Health Act. During this inspection we found some improvement had been made in this area. The provider's Mental Health Act administrator had delivered two sessions of Mental Health Act training to 14 members of staff. Staff we spoke with had sufficient understanding of parts of the Act that were relevant to their work, for example, the recording of patients taking leave from the hospital and the requirements of ensuring patients, or their nearest relatives, were aware of their rights under the Act.
- During the comprehensive inspection in November 2015, we told the provider they should review medication certificates and highlighted that the Mental Health Act Code of Practice states best practice would be to renew T2 certificates at 12 monthly intervals and T3 certificates at 24 monthly intervals. These forms allow medical professionals to prescribe medicine to people detained under The Mental Health Act and indicate whether or not the patient has capacity to understand the nature of the treatment. During this inspection we found that one patient's current T3 certificate was dated 2010 and had been completed when they were in a previous placement. The hospital

manager told had they had raised this issue with medical professionals and the Care Quality Commission but a new T3 certificate had not been completed as The Mental Health Act Code of Practice does not define a time scale for renewing these forms.

- Following the Mental Health Act reviewer visit in February 2017, both patients were visited by an independent mental health advocate (IMHA). The hospital manager told us the IMHA had found no issues that required their input currently.
- During the Mental Health Act reviewer visit in February 2017, it was found that some Mental Health Act paperwork was not available on site. We saw an action plan that showed the provider had acknowledged this and was in the process of addressing this issue within the proposed timescale.
- Both patients had received a Mental Health Act Tribunal review in January 2017. This is a court process where the appropriateness of the detention is scrutinised to ensure that continued detention is required and that the patient is received appropriate treatment. We saw positive feedback from the tribunal in regards to overall care, quality of progress notes and implementation of treatment plans.

Good practice in applying the Mental Capacity Act

- Staff completed best interest decision forms following appropriate assessments of patient's capacity. We saw that staff had decided that one patient's kitchen door should be kept locked due to recent behaviour being identified as a risk. This had been documented correctly.
- The service did not arrange formal best interest meetings. However, we spoke with a parent and nearest relative who both confirmed they were contacted regularly to gain their views on financial issues, such as informing them of the services intention to take the patients on trips or buy them things.
- The hospital manager was the appointee for both patients. This allowed them access to their finances. They told us this role had been transferred to them from the previous manager. The service had a robust system in place that audited monies spent against quarterly bank statements. We discussed how the appointee role may benefit in being formalised and included in care plans to ensure transparency and safeguard all involved. The hospital manager agreed to discuss this with their line manager.

Are wards for people with learning disabilities or autism caring?

The involvement of people in the care they receive

- During the comprehensive inspection in November 2015, we told the provider they should review how they seek feedback from patients and relatives/carers. During this inspection we found that one patient, who can communicate, had completed a feedback survey last year. We spoke to a parent of one patient and the nearest relative of one patient who both told us they speak with the hospital manager regularly and feel able to give feedback on the service. However, both were unaware that the patients were currently not registered with a GP.

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

(for example, to feedback?)

Access and discharge

- The service had produced a comprehensive document that outlined the care and support needs that one patient would require if they moved from hospital to community living. This was in line with the Transforming Care agenda which is committed to moving people with learning disabilities and autism out of hospital settings into the community.

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

Good governance

- During the comprehensive inspection in November 2015, we told the provider they should ensure they submit data to the Mental Health and Learning Disability Data Set and Mental Health Services Data Set. This is a requirement for all services, who have detained patients, to submit yearly data. During this inspection

we found that the provider had been completing this requirement and the hospital manager showed us recent correspondence that indicated they no longer had to submit data.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that systems are in place that ensure patients safety during episodes of seclusion
- The provider must ensure that the provision of care provided includes access to regular review and monitoring of patients' known and potential physical health issues.

Action the provider SHOULD take to improve

- The provider should ensure that environmental risk assessments identify all risks presented by ligature points.
- The provider should review their use of clinical psychology to ensure patients support plans accurately reflect current behaviour patterns.
- The provider should review how they document and record best interest meetings.
- The provider should review and formalise appointee arrangements for their patients.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment During episodes of seclusion, staff were unable to have clear observation of, or clear two way communication with, patients . Therefore, they were unable to monitor potential incidents of physical health emergency, deliberate or accidental harm. Patients were not receiving sufficient physical health medicine review or ongoing physical health monitoring due to a lack of registered GP and staff practice. These were in breach of regulation 12(1)(2)(a)(b)(d); 12(1)(2)(a)(b)