Cambian Fairview Hospital

Quality Report

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

Ratings

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

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.

Summary of findings

Overall summary

We rated Cambian Fairview Hospital as requires improvement because:

- Staff did not manage medication consistently across the hospital. We found errors in the storage and recording of controlled drugs and errors on patient medication records.
- The provider's policy relating to seclusion and long-term segregation was not clear. The policy stated that seclusion could only take place in low-secure services where there were dedicated seclusion facilities. The policy did not contain any guidance for staff if seclusion occurred within their service.
- The provider did not act on recommendations it identified in ligature risk assessments. Assessments completed in February 2017 were in many cases identical to the ones completed the previous year.
- The provider did not have timely access to physical health checks for patients and interventions such as blood tests and electrocardiograms on site. Staff relied upon GPs to fax over results to the service, meaning they would not be available out-of-hours or at weekends.
- Not all staff received an annual appraisal. Forty per cent of staff on Larch Court and 73% on Cherry Court had received an appraisal in the past 12 months.
- There was little evidence of patients being involved in developing their care plans or risk assessments.
- The provider did not record how they responded to concerns expressed through patients' forum meetings. Patients had expressed concerns at meetings, which managers had not responded to at the next.
- The provider had not developed a robust system to ensure that key performance indicators were used to assess the performance of the service.

However:

- Staff undertook thorough risk assessments of patients prior to and immediately after admission.
- Debriefs were held with staff after incidents of challenging behaviour to establish what could be learnt and to promote staff and patient safety.
- The provider offered a range of psychological therapies both in groups and individually.
- The provider made assessments using a recognised tool to gather detailed information about a range of behaviours in order to develop a clear plan of interventions.
- Patients had detailed positive behavioural support plans for patients to help them understand their behaviour and to look at ways to help them respond differently.
- Staff interacted with patients in a calm, respectful and caring way. We observed staff supporting patients support when they were distressed.
- Patient records contained detailed and holistic assessments, behavioural support plans and risk assessments, which referred to patients' views and preferences.
- Staff provided information to patients about treatments, how to complain, advocacy and rights in easy read format.
- There was evidence of good teamwork and mutual staff support at both ward and multi-disciplinary team levels.

Summary of findings

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Cambian Fairview Hospital

Services we looked at

Wards for people with learning disabilities or autism;

Summary of this inspection

Background to Cambian Fairview Hospital

Cambian Fairview Hospital is an independent hospital providing specialist services for adults with learning disabilities and/or autistic spectrum disorder who may have additional complex mental health problems and may be detained under the Mental Health Act 1983. The provider for this location is 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 wards, providing assessment, treatment and rehabilitation:

- Oak Court has 12 locked rehabilitation beds for men
- Larch Court has four beds for men with autistic spectrum disorder (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
- Joy Claire activity centre

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

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

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

The Care Quality Commission previously carried out a comprehensive inspection of this location from the 11 to 13 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.

A further focused inspection was carried out in February 2016. A warning notice was issued for a breach of Regulation 17(1) (2) (a) (b) (c) (f), The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Additionally, a requirement notice was issued for a breach of Regulation 13(1) (2) (3), safeguarding service users from abuse and improper treatment.

The provider sent action plans to the CQC and has addressed the issues raised with them. This inspection looked at these areas to check the provider was now compliant and assess that the measures the provider had put in place were effective.

Our inspection team

Team leader: Karen Holland, Inspection manager, mental health hospitals

Lead Inspector: Andy Bigger, Inspector, mental health hospitals

The team that inspected the service comprised four CQC inspectors, two inspection managers, a nurse, and an Expert by Experience and their support worker.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at this location.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme and to see if improvements had been made since the last inspection.

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 the location, asked a range of other organisations for information and sought feedback from patients at three focus groups.

- visited all seven wards at the hospital and the Joy Claire centre, looked at the quality of the ward environment and observed how staff cared for patients;
- spoke with 21 patients who were using the service;
- spoke with three carers of patients who were using the service;
- spoke with the registered manager, three heads of care and two deputy ward managers;
- spoke with 24 other staff members; including nursing staff, psychiatrists, psychologists, positive behavioural support lead, occupational therapists, speech and language therapists and activities co-ordinator;
- received feedback about the service from commissioners;
- spoke with an independent advocate;
- attended and observed an early morning review meeting, two multidisciplinary ward rounds and a patients forum;
- collected feedback from five patients from comment cards and 27 patients from the individual (patient) survey;
- looked at 15 care and treatment records of patients;
- looked at 40 prescription charts
- looked at eight staff records;
- carried out a specific check of the medication management on wards including controlled drugs;
- and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to 21 patients, individually and as part of a patients' forum. Ten patients said staff were caring and kind, listened to them and treated them with respect. In the patient survey, 20 patients said that staff were polite and treated them with respect. One commented that staff calmed them down when they were distressed. However, four patients said that staff did not listen to them all the time, and two patients on Oak Court said that night staff were less helpful and treated them differently.

Nine patients said they felt safe and said that staff looked after them. One patient said he did not feel safe and two patients said there were too many people on the wards for staff to be able to keep them safe. One patient said that he felt safe but had not done so when he was on a different ward and another patient had attacked him. However, in the patient survey 18 patients said they felt comfortable and safe and nine patients said they did not.

We spoke to three carers. One said that the provider had not involved them in their relative's care and that staff did not always inform them of how their relative was doing. They also said that doctors and other members of the multi-disciplinary team did not always return their calls

Summary of this inspection

when requested to do so. Two carers said that communication was sometimes difficult, especially where English was not the first language of the staff member and that visiting rooms were too small.

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?

Requires improvement

We rated safe as **requires improvement** because:

- Staff did not manage medication consistently across the hospital. We found errors in the storage and recording of controlled drugs and errors on patient medication records.
- Staff restrained and nursed patients in their bedrooms, which they could leave if they chose. However, the provider's policy relating to seclusion and long-term segregation was not clear. The policy stated that seclusion could only take place in low-secure services where there were dedicated seclusion facilities. The policy did not contain any guidance for staff if seclusion occurred within their service.
- There was a high number of restraints, with 649 recorded instances in a six-month period to December 2016.
- Mandatory training compliance was 67% across the hospital.
- The provider did not act on recommendations it identified in ligature risk assessments. Assessments completed in February 2017 were in many cases identical to the ones completed the previous year.

However:

- The provider had reviewed the number of staff on the wards to ensure there were enough staff to keep people safe.
- Staff undertook thorough risk assessments with patients prior to and immediately after admission.
- Safeguarding training compliance was 95%.
- All permanent staff had received training in de-escalation and restraint techniques (the management of actual and potential aggression). Agency and bank staff were not involved in restraint unless they had received this training.
- Debriefs were given after incidents of challenging behaviour to establish what could be learnt and to promote staff safety.
- Where possible, staff based restrictions on individual risk assessments rather than blanket rules which affected everyone.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- The provider did not have timely access to physical health checks and interventions such as blood tests and electrocardiograms on site. Staff needed GPs to fax results to the service, meaning they would not be available out-of-hours or at weekends.

Summary of this inspection

- Not all staff received regular supervision. Monthly supervision rates across the hospital were 67% for the past 12 months.
- The provider did not provide figures in relation to staff that had completed MHA or MCA training. Staff we spoke to said they had done on line training. One commented that the training was very brief, although another said they felt they had sufficient information to fulfil their role.
- Not all staff received an annual appraisal. Forty per cent of staff on Larch Court and 73% on Cherry Court had received an appraisal in the past 12 months. One member of staff said that prior to their recent appraisal, the next most recent one had been five years ago.

However:

- The provider offered a range of psychological therapies both in groups and individually.
- The provider made assessments using a recognised tool to gather detailed information about a range of behaviours in order to develop a clear plan of interventions.
- Patients had detailed positive behavioural support plans to help them understand their behaviour and to look at ways to help them respond differently.
- Psychologists and other multi-disciplinary staff delivered specialist training in relation to individual patients to ensure staff had the knowledge and skills to support them appropriately.

Are services caring?

Good

We rated caring as **good** because:

- Ten patients said staff were polite and treated them with respect. Four comments cards from patients, of a total of five, were also positive about how staff supported them.
- We observed staff interacting with patients in a calm, respectful and caring way. We saw them offer patients support when they were distressed.
- Staff we spoke with showed understanding of patients' needs and aspirations and were enthusiastic to provide high quality care.
- Patient records contained detailed and holistic assessments, behavioural support plans and risk assessments, which referred to patients' views and preferences.
- Patients had access to advocacy. The provider displayed information about this service across all the wards in the hospital.
- The provider ran a patients forum, which could raise issues with managers.

Summary of this inspection

However:

- Four patients said that staff did not listen to them all the time.
- Staff did not record that patients had been involved in formulating care plans or risk assessments.
- Carers we spoke with said that staff did not always involve them in their relatives care and keep them informed.

Are services responsive?

Good

We rated responsive as **good** because:

- There was a range of activities provided on the wards with an aim of providing 25 hours a week of meaningful activities to patients.
- The provider had worked with commissioners to enable patients to move on to less restrictive placements.
- Staff provided information to patients about treatments, how to complain, advocacy and rights in easy read format.
- The provider enabled patients to take leave and did not admit patients into beds that were vacant because patients were on leave.
- Patients had access to snacks and drink throughout the day.
- There were a range of rooms and a centre available for therapy sessions, activities and individual time with staff.
- The provider was able to cater for a variety of food intolerances and preferences.

However:

- Most of the patients we spoke with said that the food was poor.
- Patients were unhappy that they had no choice over the colour schemes in their bedrooms.
- The provider gave opportunities for patients to feed back about the service through patients' forum meetings and their complaints processes. However, there was no evidence that managers responded to concerns expressed through patients' forum meetings. Patients expressed concerns at meetings, which managers had not responded to at the next.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The provider had not developed a robust system to ensure that they used key performance indicators to ensure they met targets in relation to training, supervisions, appraisals and audits and to assess the performance of the service.
- Forty per cent of staff on Larch Court had received an appraisal in the last 12 months.
- Mandatory training rates were 67% across the hospital.

Summary of this inspection

- Managers did not monitor supervision adequately to ensure that all staff were receiving regular individual supervision.

However:

- All patients had a detailed positive behavioural support (PBS) plan, which aimed to reduce instances of challenging behaviour. A programme had been established to train all staff across the hospital, which had started in January 2017.
- There was evidence of good teamwork and mutual support at both ward and multi-disciplinary team levels.
- Staff learned from incidents through individual and team debriefs and supervisions and multidisciplinary team meetings.
- The provider had ensured that staff received training in safeguarding and the management of actual and potential aggression.
- The provider did not employ agency staff who were not compliant with mandatory training.

Detailed findings from this inspection

Mental Health Act responsibilities

- Medication records for patients had the correct consent to treatment forms T2 or T3 in place and attached to medication charts. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.
- Mental Health Act (MHA) paperwork was correctly completed in all cases where patients had been detained under the Act. Staff had informed patients of their rights regularly and had recorded this in the patients' notes. Detention paperwork was available to the inspection team and was securely stored on site.
- The provider did not provide figures in relation to staff that had completed MHA training. Staff we spoke to said they had done on line training. One commented that the training was very brief, although another said they felt they had sufficient information to fulfil their role.
- Staff were aware of who to go to if they required more information. MHA administrators were on site and supported the staff teams in relation to legal requirements, tribunals. MHA administrators completed audits every six months and sent to the provider's quality team. Section 17 leave paperwork was in place. The provider when needed provided more specialist legal advice centrally.
- Patients had access to independent mental health advocates (IMHA). The provider displayed information on notice boards on all the wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to said they had done on-line training but that they were not involved in mental capacity assessments or best interests meetings. The provider did not provide details of the number or percentage of staff who had completed this training. Seven staff had undertaken a more detailed course in relation to completing mental capacity assessments.
- Staff were aware of the provider's policy on deprivation of liberty safeguard (DoLS). The provider had made eight DoLS applications made between July and December 2016. Staff had completed paperwork and applications we looked at were in date. The Mental Health Act administrator ensured that nurses completed assessments and chased best interests assessors to ensure they gave this high priority.
- Staff had completed mental capacity assessments for patients who lacked capacity. These were detailed, clear and related to specific decisions and aspects of patients' lives and treatment. We saw that staff supported patients to make decisions for themselves when they were able.
- The provider told us that audits took place in relation to the Mental Capacity Act as part of the Mental Health Act audit.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- The layout of the wards did not allow staff to observe patients clearly and easily. On Oak and Redwood wards the nursing offices were outside the ward environment and on Elm, Laurel and Sycamore there were insufficient lines of sight to observe patients throughout all parts of the ward. The provider managed this by the use of close circuit television and observations.
- There were several ligature points throughout the hospital. A ligature point is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Not all ligature points were contained in the ligature risk assessments for the individual wards, which the hospital had recently reviewed. These included cupboards, window handles, hand dryers, and soap dispensers in the communal bathrooms. The hospital had identified some risks and potential actions to rectify these. However, the risk assessments and recommendations were identical to those contained in the ligature risk assessments from March 2016, indicating that the hospital had identified risks and made recommendations, but had not taken action to mitigate the risks they had identified. Staff managed risk by observations and individual risk assessments.
- All wards in the hospital were single sex and therefore complied with guidance on single sex accommodation.
- The provider supplied lanyards to the inspection team that had only one break rather than the three breaks needed to ensure safety from the risk of a ligature.
- All staff had access to alarms and these were in use across the hospital.
- The wards were generally clean and well maintained. However, 20 patients out of 27 in the patient survey said they were not happy with their bedrooms as there was no choice of colours or curtains. Some bedrooms needed attention and decoration, and two of the en-suite toilets on, Oak Court and Sycamore Court, were dirty. There were no patient-led assessment of the care environment survey scores available for this location. We saw that staff had cleaned the wards regularly.
- Staff checked equipment regularly, including oxygen cylinders and defibrillators, to ensure they were in good working order if they were required.
- There were clinic rooms on all wards. Some of the rooms were small but were clean, air conditioned and well organised. Staff had recorded fridge and room temperatures although on Oak Court there were several gaps. For example, staff had only recorded temperature readings on 17 days in November 2016. Although most medications were in date, we found two examples of medications which had passed their expiry date. On Laurel Court, a patient was being dispensed eye-drops, which had an expiry date of September 2016. On Oak Court, we found a medication, no longer required by the patient, which expired in September 2016 that staff had not removed and disposed of. We raised these issues with the provider and they addressed them immediately.
- Stock balances recorded in medication charts were inconsistent and did not always reflect the remaining amount of medication in stock. We found examples of

discrepancies on Laurel Court and Larch Court of both missing and surplus medication. On Elm Court, the medication in the Controlled Drugs cabinet did not correspond with what was recorded in the controlled drugs register. Staff had labelled medication incorrectly and had not recorded in the register medication that was in the cabinet. Another record for a patient from Larch Court (who had no controlled drugs cabinet and so used the one on Elm) stated that his prescription for a medication had ceased and that no tablets remained. However, there was one tablet in the cabinet, which had not been disposed of. Staff had also completed page numbers in the register incorrectly. This was contrary to the national institute for health and care excellence guidance on the safe use and management of controlled drugs and the provider's own policy.

- Deputy ward managers undertook regular environmental risk assessments. Staff tested equipment regularly and ensured it was in good condition.

Safe staffing

- The provider had reviewed the number of staff they felt was needed to run the service to 3 heads of care, five deputy ward managers, 32 nurses and 106 support workers, including senior support workers. The provider stated that in December 2016, there were 11 nursing vacancies and 48 support worker vacancies, although they had recruited 15 support workers who had not yet started.
- Between December 2015 and December 2016, 81 out of 172 staff had left, which equates to a turnover rate of 47%. However, recent data indicated, staff turnover stood at 36% for the 12 months to 28 February 2017. In December 2016, the percentage of vacancies across the hospital as a whole was 19%. Staff sickness between December 2015 and December 2016 was 3.7%.
- There were qualified nurses on all the wards at all times. Wards were rarely short staffed and patients were able to spend time with their named nurse regularly, although one patient said that nurses were too busy to give them individual sessions. There were sufficient staff to carry out physical interventions where necessary.
- The provider used both bank and agency staffing. Over a three-month period from 1 September 2016, the provider covered 1465 shifts using bank staff and 1572 shifts using agency staff. The provider did not record how many shifts they had not filled across the site. They estimated that they were unable to cover approximately ten shifts per week across the whole site due to staff absences. We saw that the hospital tried to ensure that agency staff were familiar with the hospital and with patients. The hospital ensured that agency staff completed the same training as permanent staff. Where this had lapsed, the hospital did not approach those staff to cover shifts. When staff rang in sick, ward staff attempted to fill gaps by ringing permanent staff, the hospital's bank staff and agency staff in order to provide cover.
- There were not always enough staff to guarantee all planned activities could take place. Most staff said they rarely had to cancel activity sessions due to a shortage of staff and when this happened, they tried to organise an alternative. However, two members of staff said that when the ward was full and there were high levels of observations required, or when there had been a number of incidents requiring high levels of staffing, there were occasions when they needed to rescheduled trips or activities. Four patients said they did not get see their nurse regularly and the independent advocate stated that staff shortages were regularly discussed at patient forum meetings and in many of her individual sessions with patients. Four patients also commented that there was not enough to do, although one patient said that when there were insufficient staff on the ward, staff still took patients out.
- Patients told us they were happy with their leave arrangements but were not always able to access it. We also saw an e-mail from one of the doctors indicating they would suggest increasing a patient's level of observations but that the hospital did not have sufficient staff to facilitate this.
- One of the doctors said that 18 of the last 31 admissions had been emergency placements and this had put additional pressure on the service and on staffing levels.
- There were three doctors employed by the hospital, each responsible for a number of wards. Doctors stated there was sufficient out of hours cover and that they would be able to attend quickly if there was an emergency.
- The hospital stated that 80% of staff would be up-to-date with mandatory training by the end of 2016 but at the time of inspection, this stood at 67%. On Cherry Court, 14 out of 19 staff, and on Larch ward seven out of 17 staff had completed all their mandatory training.

Requires improvement

Wards for people with learning disabilities or autism

Assessing and managing risk to patients and staff

- Staff undertook detailed assessments in relation to risk for new patients and regularly reviewed and updated them. We looked at 15 care records all of which showed that staff completed risk assessments for all patients using the short-term assessment of risk and treatability. The historical clinical risk management tool, HCR-20, was also used with some patients to assess levels of risk in relation to potential violence. Staff completed daily risk sheets that used a red, amber and green colour code for easy access on information regarding patients current risk status.
- Managers' use of blanket restrictions was limited and appropriate to a secure environment. Staff made efforts to ensure that restrictions were person centred and based on individual risk assessments. This included practices in relation to smoking, mobile phone and internet usage and access to outdoor areas.
- The provider observed patients appropriately to minimise risk in relation to ligatures. Staff completed individual risk assessments to ensure the safety of patients.
- All staff received training in the management of actual and potential aggression. Managers told us that bank or agency staff not trained in these techniques were not involved in patient restraint. Each patient had a positive behavioural support plan, which identified risks and different strategies to deal with challenging behaviours in the least restrictive way. Staff used verbal de-escalation and distraction to try to manage difficult situations and told us they only restrained patients when this was not effective and the patient or others were at risk.
- There were 649 incidents of restraint in a six-month period ending in December 2016. Of these, 307 incidents took place on Larch Court, 157 took place on Redwood Court and 125 took place on Cherry Court. There were 23 incidents of restraint on Elm Court, 22 on Oak Court, 12 on Laurel Court and three on Sycamore Court. There were 12 incidents of prone restraint, all on Larch Court. The hospital had one patient who had a care plan for prone restraint, but staff said they were working to minimise this and had not restrained them in this way for over six months.
- In 2016, there were 234 occasions where staff used rapid tranquilisation to administer medication to patients. There had been 32 occasions of rapid tranquilisation between 1 January and 21 February 2017. Where staff administered rapid tranquilisation, they monitored and recorded this appropriately.
- The provider had no seclusion facilities and stated that it did not seclude patients. The provider had policies in place in relation to seclusion and long-term segregation, which stated that seclusion could only take place in Cambian's low-secure services, in accordance with the policy and the Mental Health Act Code of Practice. The code of practice states that seclusion is the supervised confinement and isolation of a patient away from other individuals, in an area from which the patient is prevented from leaving. The provider's policies on seclusion include this definition. Staff stated that they did not practice seclusion because they did not have a seclusion facility and that the policy made it clear that seclusion could not take place in a locked rehab service.
- The provider's policy relating to seclusion and long-term segregation was not clear. The policy stated that seclusion could only take place in low-secure services where there were dedicated seclusion facilities. The policy did not contain any guidance for staff if seclusion occurred within their service. We were, therefore, concerned that staff did not have the necessary guidance to ensure safeguards under the Mental Health Act code of practice were followed for patients.
- Ward staff and heads of care stated that they did not seclude patients and therefore did not complete any seclusion paperwork. Staff restrained patients in their rooms but stated that patients were free to leave if they wished, and carried out close observations to ensure their safety and the safety of other patients on the ward.
- Staff knew how to identify safeguarding concerns and reported them through the hospitals reporting system. Managers had systems in place to ensure that they reported safeguarding concerns to the local authority safeguarding team and to the police where appropriate. Managers were working with the local safeguarding team in relation to a number of safeguarding referrals. Ninety five per cent of staff across the hospital had completed safeguarding training.
- Systems were in place to ensure medications were stored and managed safely. For example, staff recorded the number of tablets remaining in a patient's prescription each time they dispensed medication. However, we found that recording medication counts

was inconsistent across the hospital and within records, with significant gaps where staff had not done this. We also found examples where the current number of tablets recorded did not correspond to the number of tablets remaining.

- The provider had built a new family room to ensure that if children visit the hospital, they can ensure their safety. This was not on the wards and staff would try to arrange access off-site following an assessment of risk.

Track record on safety

- There were two serious incidents in the previous 12 months. One concerned allegations against staff members which is the subject of a police investigation.

Reporting incidents and learning from when things go wrong

- The provider had a paper system for reporting incidents. Staff knew what to report and how to submit incident forms. Staff completed detailed and well-recorded incident forms, which the nurse in charge monitored. Heads of care discussed incidents in the daily multi-disciplinary handover meetings, which agreed any changes to risk assessments and care planning. One member of staff stated that this had improved since last year and staff were now encouraged to report incidents and that staff used these reports to update risk assessments.
- Nurses debriefed staff after incidents, usually at the end of the shift, but later if this was more appropriate. These could be individual or involve the whole team, depending on the nature of the incident. The psychologists conducted formal, individual debriefs and team debriefs as part of reflective practice meetings. Staff said they felt supported by this process. However, we spoke to one member of staff who felt unsupported, with little opportunity to talk to management about incidents that had happened on the ward and how it had affected them.
- We reviewed four safeguarding investigations. Staff had reported all incidents appropriately to the local authority and created safeguarding plans for patients, which looked at ways to reduce the likelihood of a similar incident happening again. Staff had reported all concerns appropriately and the provider had met with the social worker to co-operate with their investigations. Learning from incidents was shared through the various types of debriefs, handovers and through local changes to policy, practice and training. There were monthly team meetings where staff shared good practice and lessons learned.
- We saw examples of letters written from the provider to patients and carers when things had gone wrong.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at 15 care records across the service. All the records we looked at contained detailed information about patients, which covered a range of different areas and behaviours and was individualised. This included detailed and thorough positive behavioural support plans, which focused on working with patients to understand their behaviours, particularly ones that were aggressive and challenging. The plans looked at ways to help patients respond differently. Assessments by psychologists, occupational therapists and speech and language therapists were also in place and up-to-date. Staff completed detailed care plans and reviewed them regularly.
- We saw an example where provider had used the brief behavioural assessment tool, which gathered detailed information about a patient in relation to repetitive, physically aggressive and self-injurious behaviours and developed a clear plan of interventions. Each behaviour was analysed, rated according to severity and then prioritised in accordance with this.
- The provider monitored patients' physical health and made referrals to GPs in relation to physical health issues. However, the provider did not routinely keep copies of physical healthcare checks on patient files. When we requested these, staff had to contact patients' GPs in order to obtain a copy. Staff stated that when GPs undertook these assessments, they kept them on their own systems and so were not available for hospital staff to view without requesting copies. We also saw that the provider did not keep patients' electrocardiogram and blood test results in the patients' notes, meaning that

staff did not have timely access to these results on site. Staff needed to request that GPs fax these results, meaning that they would not be available out of hours or at weekends.
- The provider kept confidential patient information securely and ensured it was accessible to staff if they needed it.

Best practice in treatment and care

- We looked at medication charts for all seven wards and examined 40 prescription records in detail. Doctors told us that they followed guidelines from the national institute for health and care excellence (NICE) when prescribing medication and we saw this in an examination of the prescription charts. Doctors said they used NICE guidelines most of the time but would also consider treatments that were off licence if they obtained the consent of the patient and clinical opinions and judgements supported this.
- The provider offered a range of psychological therapies, including group and individual therapies. The psychologists worked closely with the positive behavioural support specialist, both to provide psychological interventions to patients and to train staff. The provider discussed plans to develop a team around the specialist to increase staff knowledge in this area.
- GPs came to the hospital every Friday to undertake physical health checks. The hospital worked with GPs to ensure access to all aspects of physical healthcare including specialist treatments such as diabetes and eye screening. Access to specialist physiotherapy was limited as the provider employed one physiotherapist, based in Sheffield, covering the whole organisation. One doctor said there was an expectation that the organisation could use their own resource, meaning that they could not refer patients to the local team.
- The provider used the health of the nation rating scale to record patients' progress. Staff completed these during wards rounds on our inspection. The provider also used the global assessment of progress tool to measure how patients had progressed.
- Clinical staff participated in audits, for example around positive behavioural support planning.

Skilled staff to deliver care

- The teams consisted of a head of care who covered two or three wards, deputy ward managers, qualified nurses and support workers. In addition, there were psychiatrists, psychologists and psychology assistants, speech and language therapists, occupational therapists and a positive behavioural support specialist. The provider did not employ social workers but had developed links with the local social work team who came in to undertake safeguarding investigations. A number of these staff were very experienced. Specialist staff and nurses were appropriately qualified.
- Staff received a two-week induction. This included mandatory training, including e learning.
- Appraisal rates varied across the wards and the provider did not supply up-to-date figures for the hospital as a whole. Managers acknowledged that appraisals had been a problem in the past but stated that they had made significant improvements. One member of staff told us they had recently had an appraisal but prior to this, they had not had an appraisal since 2012. At Elm Court, 95% of staff had had an appraisal in the past 12 months, and 93% of staff at Laurel Court. Redwood Court was 86%, Sycamore 82%, Oak Court 76%, and Cherry Court was 73%. However, on Larch Court only 40% of staff had received an appraisal in the past 12 months. Managers said they were working to address this.
- Managers told us that individual supervisions should take place every eight weeks and cover training, service issues and personal and professional development. Some staff told us that they received supervision regularly but it was not clear how often this took place. One member of staff reported that they had no supervision and no opportunity to talk about how they were. On Larch Court, eight out of 20 staff received no supervision in October 2016, and in January 2017, ten out of 29 staff on Cherry Court did not receive supervision.
- Psychologists and speech and language therapists delivered specialist training in relation to individual patients. The manager discussed plans to develop positive behavioural support training. The provider had started to train staff in positive behavioural support from January 2017. One member of staff said the provider assisted her to access specialist training but another said she was unable to attend a course relevant to her job.
- The manager stated that there was a clear process in relation to addressing staff performance, which identified issues and put in additional support to enable

workers to address issues where possible. The provider had a disciplinary process to use where this was required. At the time of inspection, the provider had suspended seven staff from duty pending investigation.

Multi-disciplinary and inter-agency team work

- There were daily multidisciplinary meetings to review patient care. There were, additionally, four-weekly ward rounds attended by patients and members of the multi-disciplinary team to review patient care. Handovers took place on each ward between shifts to discuss any issues that had arisen over the previous 12 hours and ensure that staff on the following shift were aware of relevant information about patients.
- The provider participated in care programme approach meetings and community treatment reviews with commissioners, care co-ordinators and families when appropriate. Staff also communicated with other professionals in relation to safeguarding, ongoing issues in relation to patient care and discharge.

Adherence to the MHA and the MHA Code of Practice

- We looked at the medication charts for all the wards. All records had the correct consent to treatment forms T2 or T3 in place and attached to medication charts. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.
- We looked at 15 care records. Mental Health Act (MHA) paperwork was correctly completed in all cases where patients had been detained under the Act. Staff had informed patients of their rights regularly and had recorded this in the patients' notes. Detention paperwork was available to the inspection team, was in good order and securely stored on site.
- The provider did not provide figures in relation to staff who had completed MHA training. Staff we spoke to said they had done some on line training. One commented that the training was very brief, although another said they felt they had sufficient information to fulfil their role.
- Staff were aware of who to go to if they required more information. MHA administrators were on site and supported the staff teams in relation to legal requirements, tribunals. MHA administrators completed audits every six months and sent to the provider's quality team. Section 17 leave paperwork was in place. The provider when needed provided more specialist legal advice centrally.
- Patients had access to independent mental health advocates (IMHA). The provider displayed information on notice boards on all the wards.

Good practice in applying the MCA

- Staff said they had done on-line training but that they were not involved in mental capacity assessments or best interests meetings. The provider did not provide details of the number or percentage of staff who had completed this training. Seven staff had undertaken a more detailed course in relation to completing mental capacity assessments.
- Staff were aware of the provider's policy on deprivation of liberty safeguard (DoLS). The provider had made eight DoLS applications made between July and December 2016. Staff had completed paperwork and applications we looked at were in date. The Mental Health Act administrator ensured that nurses completed assessments and chased best interests assessors to ensure they gave this high priority.
- Staff had completed mental capacity assessments for patients who lacked capacity. These were detailed, clear and related to specific decisions and aspects of patients' lives and treatment. We saw that staff supported patients to make decisions themselves when they were able.
- The provider told us that audits took place in relation to the Mental Capacity Act as part of the Mental Health Act audit.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We spoke to twenty-one patients and observed how staff interacted with patients across the seven wards.

Requires improvement

Wards for people with learning disabilities or autism

Ten patients said that staff supported them well and treated them with respect. In the patient survey, 20 patients said that staff were polite and treated them with respect.

- One commented that they calmed them down when they were distressed. However, four patients said that staff did not listen to them all the time, and two patients on Oak Court said that night staff were less helpful and treated them differently.
- We received five comments cards from patients. Four of these were positive about how staff supported them and treated them with respect.
- We saw staff speaking with patients in a caring and respectful way, offering calm and skilful support when they were distressed. We observed staff restraining patient, making efforts to preserve their privacy and dignity in difficult circumstances.
- Staff we spoke with showed understanding of patients' needs and aspirations. They were enthusiastic to provide high quality care to patients.

The involvement of people in the care they receive

- Staff did not record that they had involved patients in formulating care plans and risk assessments. Staff had assessed some patients as lacking the capacity to understand their care plans. Some patients had signed their care plans. Patients we spoke with confirmed they had not been involved in this process. However, care plans and positive behavioural support plans were detailed and holistic and contained information about patients' views and preferences. One patient said he could approach staff to include things in his care plans if he wanted.
- Patients had access to advocacy services and the provider ensured they had displayed information regarding these services across all the wards. This included access to independent mental health and independent mental capacity advocates. An independent advocate attended for 14 hours each week, split across the whole hospital site, seeing patients individually and facilitating patient forum meetings.
- The independent advocate facilitated patient forum meetings, which took place monthly. We attended one of these meetings during the inspection and saw records from two other meetings. Patients and carers also gave feedback on the service through the patient and relative/carer surveys, which took place in December 2016 and January 2017.
- We spoke to three carers. One carer said that they were not involved in their son's care, despite requesting to speak to his doctor. One person said that staff were sometimes aloof and did not communicate with them. However, in the relative/carer survey, all nine people said they felt staff listened to them and seven said that the staff were friendly and caring and made them feel welcome.
- An advocate facilitated yearly surveys for both patients and carers and relatives. The current survey asked 16 questions and 27 patients provided answers. The relative/carer survey asked eight questions and nine carers participated.

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

(for example, to feedback?)

Good

Access and discharge

- Average bed occupancy over the previous six months was 90% or over for six of the seven wards in the hospital. On Larch Court the figure was 100%, Cherry Court was 99%, Sycamore Court 96%, Oak Court 95%, Elm Court 92%, Redwood Court 90% and Laurel Court 81%. This exceeded the 85% recommended by the Royal College of Psychiatrists. However, the provider did not admit new patients into beds that were vacant because patients were on leave.
- Cambian Fairview took referrals nationally. Managers and doctors told us that discharge rates were high, with a turnover of up to 50% but we were not able to verify these figures. Clinical commissioning groups funded placements.
- Male patients moved onto different wards as they progressed towards discharge and required less support. Doctors took decisions after discussion with the multi-disciplinary team and with the patient, and planned this at an appropriate time. We spoke with one

patient however, who said one of the doctors had moved him against his wishes. As there was only one female ward, female patients did not move within the hospital.

- The hospital did not have access to psychiatric intensive care. However, one of the doctors stated that 18 out of the last 31 admissions had been emergencies, which they had not been able to plan. The manager said that these patients were sometimes moved from the hospital after a short period of time when a psychiatric intensive care bed became available.
- The provider said they had not had any delayed discharges in the last six months. In 2016, they had 31 admissions and 33 discharges. Of the 31 discharges, 90% were to less restrictive environments and 10% were sideways moves to other hospitals. However, a manager told us that they had given notice to the clinical commissioning group in relation to one patient but that the CCG had been unable to find him an alternative placement. The average length of stay of current patients was 337 days and the average length of stay for patients who had been discharged in the last 12 months was 749 days.

The facilities promote recovery, comfort, dignity and confidentiality

- In the patient survey, completed in January 2017, 22 of the 27 patients who responded said they were not happy with the food. The provider identified food as a major issue arising from complaints about the service. Five patients we spoke with said they did not like the food and two said that they enjoyed it. The menus offered some choice but patients said the food was sometimes cold, not properly cooked and the choice was limited. The provider had not made a formal response to this.
- Patients had access to drinks and snacks when they wanted them. Some wards, such as Cherry Court, did not allow access to patients, but patients could make drinks in the therapy kitchen.
- All wards had clinic rooms where staff could see patients. On Larch Court, where there were four patients, there was a large activity room and some smaller rooms where patients could meet with their visitors. On other wards, for example Sycamore Court, where there were more patients, there was a lounge and dining rooms but no smaller rooms for patients to use. The provider told us of plans to reduce the patient numbers on some of the wards. There was an activity centre where up to 15 patients and staff could attend and participate in a variety of activities. These included arts and craft sessions, discos, kitchen activities, trampolining, lego therapy and personal shopping days. The provider had built a new family room on site but away from the wards, for meetings and for relatives and carers to meet with patients. There were also some rooms for MDT meetings in the reception area of the hospital, away from the wards.
- Patients had access to outside areas. Staff did not routinely lock these areas. If supervision was required for individual patients, this was individually risk assessed. There was access to activities on the ward and at the activity centre. Access to activity extended to the weekends but to a lesser extent as the occupational therapy staff and activities co-ordinator worked Monday to Friday.
- Patients said they were unhappy with their bedrooms because they could not choose the colour scheme or curtains. However, patients personalised their rooms and there was secure storage for their possessions.
- Patients could make private phone calls on their mobile phones where this had been risk assessed. Staff made other arrangements where appropriate.

Meeting the needs of all people who use the service

- Staff and patients with physical disabilities could access the wards and other areas in the hospital at ground floor level. However, not all parts of the hospital had lifts, meaning some areas were inaccessible to them. The provider stated that managers would make arrangements to place workers in accessible parts of the building and meetings organised on the ground floor. The provider placed patients who could not access upstairs bedrooms, in ground floor accommodation.
- The provider displayed information about treatments, rights, advocacy and how to make a complaint on notice boards across all the wards. Speech and language therapists produced leaflets and grab sheets in an easy read format to aid interaction with patients who had limited or no verbal communication. There were no leaflets or notices in other languages explaining how to access information. Staff used interpreters as and when needed.
- Patients raised issues at the Patient Forum meetings but we could not see that these had received a response. The Patients' Forum we attended during the inspection

did not include any feedback from managers about how concerns recorded during the previous meeting. Minutes of two other meetings did not include responses to issues raised.
- The provider catered for a range of food intolerances and preferences. Patients chose their food from a range of menu options. This included religious and cultural requirements and preferences.
- The hospital had a small multi-faith room on site, which patients accessed when required.

Listening to and learning from concerns and complaints

- The provider had a complaints policy and had systems in place to monitor individual complaints. Most patients were aware of how to complain to the hospital when they had issues to raise with the provider. In the patients' survey, only three patients said they did not know how to complain. Patients we spoke to said they knew how to complain although two patients said they were not happy with the response they had received. One patient said they would not complain in case it affected their placement.
- The service received 23 complaints between December 2015 and December 2016. Four of these were upheld and none were referred to the Ombudsman.
- Staff knew how to receive and manage complaints and managed most complaints in accordance with the provider's policy. Staff recorded and acknowledged complaints promptly and investigations usually started immediately. However, on one occasion the investigation did not start until eleven weeks after the complaint was made.
- On three occasions, staff had not recorded any conclusions or outcomes in the complaints log, but staff had documented these complaints extensively in a separate file and had completed root cause analyses. Staff raised safeguardings appropriately when needed.

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

Requires improvement

Vision and values

- Cambian Healthcare state that their vision is to become the highest quality provider of specialist behavioural health services in the UK. Everyone has a personal best, everyone can find something to aim for, everyone can achieve something special and everyone should have the opportunity to strive for it, no matter what their situation and what specific challenges they might be facing.
- Staff did not articulate the provider's values during the inspection. However, they were motivated to help patients move on to less restrictive placements and develop their independence. They cited examples of patients who had displayed very difficult behaviours but who had moved on to community placements.
- Staff were aware of senior managers in the hospital and said they were approachable and visible on the wards. Some staff were aware of the chief executive's whose recent visit and described this as inspiring.

Good governance

- Mandatory training compliance across the hospital was 67%.
- The provider had worked to address appraisal rates, which varied across the wards. Some staff had not received an appraisal in the last 12 months. On Larch Court, only 40% of staff had received an appraisal. We saw that the manager had prioritised this area and rates for other wards were increasing. Elm Court (95%) and Laurel (93%) had the highest rates for appraisals.
- The manager did not have easy access to the correct compliance rate for the supervision of staff. The provider gave monthly supervision rates for individual wards. For the hospital as a whole, this stood at 67%. However, the provider's supervision target was five supervisions in a 12-month period, so that information provided about its compliance did give a true reflection of its performance. The manager stated that they were working to ensure that all staff received at least eight-weekly individual supervision to look at training, clinical and job related issues and professional and personal development. Group supervision was additional to this. Staff we spoke with said they received regular, often monthly supervision, and that they could ask for additional, informal supervision as required. One staff however, said that she did not feel supported and rarely received supervision.
- The provider ensured there was a good mix of staff on wards at all times, including qualified nurses, and that

they rarely needed to cancel activities. However, there was a perception amongst some staff and patients that staff were sometimes too busy to spend individual time with patients due to high levels of need, complexity and observations. In response, the provider had recently increased the numbers of staff they estimated they needed to provide a service and were actively recruiting to reach this level.

- The hospital employed three heads of care who each had oversight of a number of wards. They were able to discuss individual risk assessments, observations and staffing requirements daily at the wards' morning meeting.
- Staff participated in clinical audits in relation to a range of areas, such as medication, environment, health and safety, ligatures and physical health. The provider had recently produced a draft policy in relation to ensuring that their audit schedule demonstrated their compliance with national institute for health and care excellence of guidelines concerning treatment and care. It was not clear when this was due to be completed.
- Staff reported incidents appropriately through the providers systems and processes. Staff made safeguarding referrals to the local authority and notifications to the CQC in a timely fashion. MHA processes were in good order and the MCA was used appropriately with clear and detailed assessments in place where patients lacked capacity.
- Staff learned from incidents through individual and team debriefs and supervisions and multidisciplinary team meetings.
- The provider had not developed a system to ensure that they used key performance indicators to ensure that they had met targets in relation to training, supervisions, appraisals and audits and to assess the performance of the service.
- Managers said they had sufficient authority to do their job and that discussions with the hospital manager were now very open. Management took their concerns seriously and the multi-disciplinary team worked extremely closely to support each other.

Leadership, morale and staff engagement

- The provider reported that the sickness rate for the service between December 2015 and December 2016 was 3.7%. At the time of inspection, seven staff were suspended.
- There were no bullying and harassment cases. Staff were aware of the whistleblowing policy and said they felt confident to raise issues with their manager.
- Most of the staff we spoke with said that morale was high and that they felt well supported and had an open relationship with higher management. Staff felt able to have conversations about the service and make observation and suggestions about future service development. They pointed to a great sense of teamwork, both as a multidisciplinary team and at ward level where everyone looked out for each other, particularly during very stressful situations.
- We saw examples where staff had been open when things went wrong and of letters that staff had written to patients.
- The provider had supported staff to undertake training in relation to their professional development, including support to undertake nurse training.

Commitment to quality improvement and innovation

- Laurel Court and Cherry Court had joined the accreditation for in-patient mental health services (AIMS) and the service war working towards accreditation by the National Autistic Association.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that Controlled Drugs are correctly labelled, that medications in the CD safe are correctly entered into the CD register and the register is completed using the correct page numbers.
- The provider must ensure staff have timely access on site to physical health checks and interventions such as blood rests and electrocardiograms.

Action the provider SHOULD take to improve

- The provider should ensure that staff monitor and accounted for medication consistently.
- The provider should ensure that policies make clear it is possible to seclude patients in locked rehabilitation facilities where there are no seclusion facilities. The provider should ensure that if patients are being secluded, they must be afforded the safeguards of the code of practice.
- The provider should ensure that recommendations made in the ligature audits in response to the risks staff have identified are completed.
- The provider should ensure that all staff receive yearly appraisals and regular supervision and that they monitored this effectively to assess the performance of the team.
- The provider should ensure that they respond in a timely fashion to issues raised by patients in the forum meetings.
- The provider should reduce the number of restraints across the hospital site.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider must ensure that controlled drugs are entered correctly in the controlled drugs register and that the register is completed correctly.** Staff did not always ensure the controlled drugs register corresponded to medication in the controlled drugs cupboard. This was a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider must ensure that staff have timely access on site to physical health information for patients.** Staff did not have access to blood and electrocardiogram results in patients' care records. This was a breach of regulation 12.