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:

- Emergency equipment checks were not being carried out effectively. We found that equipment had not been calibrated and defibrillator electrode pads had passed their expiry date.
- There were ligature points in all wards. They had been identified in a ligature risk assessment but no action had been taken to minimise the risk to patients. Ligature points are places to which patients intent on self-harm could tie something to harm themselves.
- Staffing did not always meet the numbers set by the hospital to meet the needs of the patients. This meant there were high levels of bank and agency staff being used to cover shifts. The hospital did not provide figures that showed the exact use of bank and agency staff.
- Medication stock was not managed effectively and we found errors when we completed random counts of medication.
- Hospital-wide learning from incidents and audits was not shared across the staff team.
- Refurbishment and redecoration was required on Oak Ward to promote recovery and comfort.
- Wards' systems and procedures were inconsistent. Staff told us this made it difficult when they were asked to cover shifts on other wards. This meant that staff's time was used understanding the systems on the ward and not always focussed on patient care.
- Future developments and improvements for the hospital did not have timescales for completion.
- One notifiable incidents had not been reported to the Care Quality Commission as required. This meant we were not aware of a serious incident affecting patient care.

However:

- There were robust systems to check that personal alarms for staff were working effectively as required.
- Staff had recently been trained in MAPA (Management of Actual or Potential Aggression) restraint techniques that were less restrictive than previous techniques used.
- There were no episodes of prone restraint used.
- Staff produced comprehensive assessments of the risks to patients, reviewed them regularly and updated them when risks changed.
- There were robust processes to monitor the physical healthcare needs of patients.
- Staff prepared detailed care plans and reviewed them regularly.
- Staff and patients interacted positively and we saw evidence that staff had an understanding of individual patients' needs and preferences.
- Patients had a wide variety of food choices and the hospital provided food for people with specific dietary requirements.
- Patients knew how to complain and the provider investigated these appropriately and told patients their findings.
- Staff said there was visible leadership in the hospital and that team morale was good.
- The hospital was working towards National Autistic Society accreditation.

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	Requires improvement 	Cambian Fairview Hospital is an independent hospital providing specialist services for people with learning disabilities who may also have other complex mental health problems, such as Autistic Spectrum Disorder, and who may be detained under the Mental Health Act 1983.

Summary of findings

Contents

Requires improvement

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 people with learning disabilities who may also have other complex mental health problems, such as autistic spectrum disorder, and who may be detained under the Mental Health Act 1983.

There are seven single-sex residential units, providing assessment, treatment and rehabilitation. The hospital can accommodate up to 63 people. At the time of inspection, there were 56 patients receiving care and treatment.

The service has a registered manager and accountable officer in place.

The hospital was last inspected in October 2014 and was found to be compliant with all regulations that were inspected.

Our inspection team

Our inspection team was led by:

Peter Johnson; Inspection Manager for CQC Hospitals Mental Health.

Victoria Green; Inspector (Team Leader) for CQC Hospitals Mental Health

The team that inspected Cambian Fairview consisted of one CQC inspection manager, three CQC inspectors, two Mental Health Act reviewers, and two experts by experience that had experience of learning disabilities services.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- held five focus groups with a variety of staff
- visited all wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- met with 18 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 18 other staff members, including doctors, nurses and social workers
- interviewed the senior managers of the service and those with lead roles within the team
- attended and observed two ward rounds, one patient forum and one handover meeting

Summary of this inspection

- spoke with eight family members or carers of patients, either in person or over the telephone.
- inspected 14 treatment records of patients
- carried out a specific check of the medication management on all wards and looked at policies and procedures relating to the hospital.

What people who use the service say

Patients told us that they had good relationships with staff and felt safe at the hospital.

They said that they felt staff listened to them and they could raise concerns if they were worried.

Patients told us that they were unhappy with the high use of agency staff during night shifts because those staff did not know them as individuals.

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 this hospital as 'requires improvement' for safe because:

- There were ligature points identified across all the wards. A ligature risk assessment identified the risks but action had not been taken to reduce the risks to patients. Ligature points are places to which patients intent on self-harm could tie something to harm themselves.
- Emergency equipment checks were not being carried out effectively. We found that equipment had not been calibrated and defibrillator electrode pads had passed their expiry date.
- Oak ward was dirty. The floors were stained and there was visible dust on surfaces along with sticky residue. There was no regular cleaning service in place.
- Environmental risk assessments were completed but lacked information on actions being taken by the hospital to address these.
- We found flammable items in cupboards. The fire extinguishers were stored at the back of cupboards and access was obstructed by cleaning equipment.
- Potential weapons of pieces of wood with nails on the end, were found in the laundry room adjacent to Larch Ward that could have been a risk to staff and visitors.
- Not all shifts were staffed to the level set by the hospital to ensure patient safety.
- There was high use of agency and bank staff to provide cover for shifts that were not filled by permanent staff. This happened mostly during night shifts.
- Activities and one-to-one sessions were sometimes cancelled due to staff shortages.
- Medication stock was not managed effectively. We found errors when we completed random counts of medication.
- Staff did not receive feedback and learning points from all incidents that happened in the hospital.

However:

- Personal alarms were checked daily before being given to staff.
- There were no episodes of prone restraint used on patients in the last 12 months
- Staff produced comprehensive assessments of the risks to patients, reviewed them regularly and updated them when risks changed.

Summary of this inspection

- Staff knew how to report an incident and gave examples of situations that required reporting.
- Staff de-briefs took place after incidents had happened in the hospital.

Are services effective?

Requires improvement

We rated this hospital as 'requires improvement' for effective because:

- Managers did not offer regular supervision or yearly appraisals to staff. This meant that staff could not access protected time to discuss clinical issues or professional development.
- Mandatory training did not include specific learning disability topics that would support staff's qualifications and experience to care for patients at the hospital with specific needs.

However

- Timely assessments took place after admission and were comprehensive.
- The service monitored physical health needs regularly and supported patients to access appropriate treatment.
- Care plans were up to date and addressed a wide variety of needs.
- Information was stored in paper records and was accessible to all staff.
- There was evidence that NICE (national institute for health and clinical excellence) guidance was used when prescribing medication for patients.
- A wide range of psychological interventions was available to patients including groups for different level of patient function.
- Staff used appropriate severity scales to measure patients' outcomes including health of the nation outcome scales (HONOS).
- The multidisciplinary team (MDT) included a wide variety of mental health disciplines. MDT meetings took place regularly.
- Poor staff performance was addressed in a timely way.
- MHA (Mental Health Act) 1983 records were completed in line with legislative guidance and there was evidence of section 17 leave being accessed regularly by patients. Patients detained for treatment can leave the hospital for short periods with permission, which is granted under section 17 of the Act.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- There were positive interactions between staff and patients. Staff were respectful and polite when talking to patients on the ward and during activities.
- Patients told us that they had good relationships with permanent staff at the hospital.
- Staff interacted with patients in a way that demonstrated they understood people's preferences and individual needs.
- 'Easy read' and pictorial information was in patients files.
- Care plans had been discussed with patients and signed by patients wherever possible.
- There was an active advocacy service in the hospital and we saw evidence of the advocate supporting people to understand their care and treatment.
- Families and carers were involved in patients' treatment where appropriate.

However:

- Patients told us that they did not always have positive relationships with some of the agency staff working in the hospital. We made the provider aware of this feedback during the inspection.

Are services responsive?

Good

We rated responsive as good because:

- There were no issues identified with bed management. Patients were able to return to their bedroom following periods of section 17 leave.
- There was a wide variety of rooms available on the wards and in the activity centre for patients to take part in groups and one to one sessions with staff.
- The kitchen provided a wide choice of meals for the patients. There was evidence that they were able to cater for specific dietary requirements.
- There was 'easy read' information and appropriate signage around the wards.
- Patients told us that they knew how to complain and we saw evidence of this in the complaint records.
- Access to places of worship was available to patients with the support of the staff.
- A new ward was open which was specifically designed to promote patients' independence.

However:

- There was no hospital-wide system for learning to be shared following investigations into complaints.

Summary of this inspection

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- There was no formal structure for learning to be shared among the staff following complaints or incidents.
- Annual appraisals of staff's work performance were not taking place.
- Monthly managerial supervision was not taking place regularly.
- Inconsistent systems and procedures were found in relation to the management of individual wards. Staff told us that this made it more difficult when they were required to cover shifts on different wards.
- There was no formal structure for wards managers to share best practice and ideas across the hospital.
- Improvements were planned for the hospital and the environment. However, there was no timetable for completion.

However:

- The provider had recently implemented a new regional management structure, which was receiving positive feedback from staff, and had supported the registered manager with their role.

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 service provider.

We found that:

- Eighty nine percent of staff were trained in the Mental Health Act 1983 (MHA).
- Twelve records we checked complied with the MHA.
- Records we reviewed showed evidence of patients' capacity to make decisions about their treatment being assessed and their consent to treatment being recorded around the time that treatment began.
- Capacity assessments were routinely reviewed
- Patients' rights were explained to them and were re-visited with patients appropriately.
- Patients had information about the Independent Mental Health Advocacy (IMHA) Service. Noticeboards on wards displayed information about the MHA and the IMHA service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Eighty seven percent of staff had completed training in the Mental Capacity Act 1985 (MCA).
- In the last six months there had been six DOLs (Deprivation of Liberty Safeguards) applications made to the local authority all of which had been authorised. Two had expired and urgent renewals had been applied for. One renewal was applied for on the day of inspection as the current authorisation had expired. All other DOLs authorisations were in order. DoLS assessments took into account if there was someone whom it was appropriate to consult about what was in the patient's best interest.
- Staff assessed patients' capacity to make decisions about their treatment appropriately in line with the principles of the MCA.
- Capacity assessments were routinely reviewed.

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

- Not all areas of the wards were visible to staff. The risk to patients was mitigated through increased observations by staff.
- There were ligature points identified across all of the wards. They had been identified in a ligature risk assessment, but no action had been taken to minimise the risk to patients. Risk was managed by increased observation of the patients.
- Cleanliness of the wards varied. On Oak Court, we saw that areas of the environment were dirty; this included stained floors and dust on the furnishings. Staff said there had been no regular cleaning service for over four weeks and that patients and staff had been attempting to keep the ward clean. We raised our concerns with staff on the ward so this could be addressed.
- There were clinical rooms on each ward. On Laurel and Cherry wards, we found that the defibrillators electrode pads had expired, one in 2013 and one in 2012. This meant that the effectiveness of the pads would be compromised if the defibrillator were used. Clinical checks had been signed as completed but the expiry dates had not been noted by staff. We raised this issue to the provider and new electrode pads were ordered immediately.
- Staff did not record when emergency equipment has last been calibrated. This meant there was potential for the defibrillator to deliver the wrong level of power. Calibration should take place yearly and monthly checks should be undertaken on the emergency equipment. This issue was raised with the provider and addressed immediately.
- Environmental risk assessments were completed but they lacked detail on the actions taken to reduce the risk to patients and staff.
- We raised concerns to the provider during the inspection regarding cupboards in the hospital. We found two examples of combustible materials being stored in front of electrical fuse cupboards. We also found that fire extinguishers were stored in two cupboards behind cleaning materials and were not easily accessible. In a laundry room adjacent to Larch ward, we found items that could have been used as a weapon. When these issues were highlighted to the provider, they took action to address them immediately.
- Personal alarms were available for staff and there were robust systems in place to ensure they were working effectively. Staff checked the alarms daily.

Safe staffing

- The total number of qualified nurses employed by the hospital was 37.
- The total number of nursing assistants employed by the hospital was 94.
- Fifteen nursing posts were vacant and six nursing assistant posts were vacant at the time the inspection was completed.
- There were enough staff on shift to meet the needs of the patients when we looked at the staffing rotas. This included two qualified members of staff on shift per ward.

Requires improvement

Wards for people with learning disabilities or autism

- The provider was not using a tool to establish the levels of staffing required to meet the needs of the patients. Senior staff discussed the level of assessed needs of individual patients in morning meetings and staffing levels were adjusted accordingly.
- The service was unable to provide figures relating to the use of bank and agency staff. The manager told us that the nurse in charge kept agency staff information. This was not made available to us. All staff reported high use of bank and agency staff at night time. The hospital risk register identified recruitment and retention as an issue. Action taken to resolve staffing shortages included a review of staff reward and retention packages.
- In the last 12 months, 27 support workers left the service and 21 qualified nurses left the service. This was 40% of the total qualified staff that left the hospital. This contributed to the high use of bank and agency to ensure there was enough staff to meet the needs of the patients. The total turnover of all staff in the last 12 months was 27%.
- Staff were 64% compliant with mandatory training across the service.

Assessing and managing risk to patients and staff

- There were no incidents of long-term segregation in the last six months from March 2015.
- In the last six months, up until July 2015, there were 30 episodes of restraint on Cherry ward, 85 on Oak ward, nine on Laurel ward, one on Sycamore ward, 113 on Redwood ward and 28 on Elm ward. Staff did not restrain people in the prone position (face down).
- Risk assessments were completed with patients on admission to the service and were comprehensive. Information was updated whenever risk changed.
- Sixty six percent of staff had completed safeguarding training. Staff we spoke with were able to describe different types of abuse and the reporting procedure for raising concerns. Twenty percent of staff were booked to attend safeguarding training within the next four weeks.
- Staff did not manage medication in a safe way. We completed random counts of medication on all wards and found that medication did not tally. Medication was above or below the amount that was recorded. This meant that staff were not accurately recording what medication was being dispensed.
- Medication administration records contained gaps that had been identified during external pharmacy audits. The managers were aware of this and had addressed the issue with staff.
- Staff had given one patient extra medication for a period of leave from the hospital. This was not recorded correctly on the medication administration record and affected the levels of medication in stock. This was raised immediately to senior staff who investigated this.

Track record on safety

- There was one recorded serious incident in the last 12 months that required investigation. This related to a patient death. Following an inquest the cause of death was found to be due to natural causes.

Reporting incidents and learning from when things go wrong

- Staff described the type of events that required reporting as incidents. Incidents were reported using a paper based system.
- The service failed to report a notifiable incident to the CQC. This was found when reviewing the service complaints information. The CQC reviewed this issue, as it was an offence however, it was not appropriate to proceed in this instance.
- Managers used an incident management process to log and review incidents. Staff could not describe learning from incidents as this was held by the administration team and not shared with the wider hospital team. The manager told us that weekly bulletins were made available to staff which included lessons learnt but staff did not not refer to this when asked.
- Staff were being supported through de-briefs following serious incidents in the service.
- Managers had sent apology letters to people when things had gone wrong an had been open and transparent abut any mistakes the hospital had made.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Requires improvement

Wards for people with learning disabilities or autism

- Comprehensive assessments were completed on admission.
- Physical examinations took place routinely with patients on admission.
- Care plan documents included two formats: a standard care plan and a person centred plan (PCP). The PCP contained a health action plan for each patient. Health action plans support people with learning disabilities to monitor health conditions that may otherwise go unnoticed. These contained holistic person centred information relating to the patient's care and had been updated regularly.
- Patients had positive behaviour support plans in place that described triggers, early warning signs and strategies for managing aggressive behaviour. Patients had been involved in the creation of the plans. They had been assisted to complete the plans themselves with the assistance of staff and the advocate. One patient had a copy of the plan in their bedroom but this was not in an accessible format for them.
- Staff recorded care plans on paper and all files were made available to us during the inspection.

Best practice in treatment and care

- Staff were familiar with national institute for health and care excellence (NICE) guidance relating to managing challenging behaviour, and were able to describe how this was incorporated in their work with patients. The service was also working towards national autism society accreditation.
- Psychological therapies were available to patients as part of their treatment plan. Staff provided high and low functioning groups to meet the differing needs of the patients. Group activities were reviewed regularly and if patient engagement was poor, individual therapy sessions were offered. Occupational therapy groups included living skills and budgeting skills aimed at increasing a person's independence.
- Staff used health of the nation outcome scales (HONOS), model of human occupation screening tool (MOHOST) and goal attainment scale (GAS) to track patient progress and outcomes. Daily living skills observational scales were utilised by occupational therapists to track patient's progress in independent living skills. This information was exported into a graph format for easy interpretation by staff.
- A local GP visited the hospital on a weekly basis to provide general healthcare. Some patients were encouraged to make appointments at this surgery in order to promote independence.
- Medical staff monitored blood tests medication as appropriate.
- Patients were supported by staff to access specific physical healthcare services including dentists and opticians.

Skilled staff to deliver care

- Patients has access to a wide variety of clinical skills and experience from the MDT (Multi-Disciplinary Team) which included doctors, learning disability registered nurses, psychologists, occupational therapists and a speech and language therapist.
- Staff undertook mandatory training although the list of core training topics did not include training that was specific to learning disabilities. This meant that staff did not have access to training that increased their knowledge and experience of working with this patient group. Topics included; active care, food safety, equality and diversity and responding to emergencies.
- The hospital induction programme was under review and was being re-designed in line with the care certificate standards. This was not yet implemented, however a standard induction was available to new staff.
- Agency staff new to the hospital received a local induction to the ward where they were allocated to work.
- Staff supervision was not taking place regularly and in line with the provider's policy. Staff appraisals were also not taking place regularly. This meant that staff did not have access to protected time to discuss their development and any clinical issues.

Multi-disciplinary and inter-agency team work

- MDT meetings took place daily in order to review patients' care. Patients' care was formally reviewed every two weeks. Enhanced Care programme approach (CPA) meetings took place every three months.
- Comprehensive handover meetings took place at the start of each shift to ensure information about patients daily presentation was communicated to staff.

Requires improvement

Wards for people with learning disabilities or autism

- Staff communicated with other agencies such as social services to co-ordinate patient treatment and discharge. Patients' local care co-ordinators were invited to meetings such as CPA meetings.

Adherence to the MHA and the MHA Code of Practice

- Eighty nine percent of staff were trained in the Mental Health Act (MHA).
- Staff assessed individual patients' capacity to make decisions and capacity assessments were regularly reviewed to ensure they were up to date.
- Front line staff explained patients' rights to them on admission and again every two weeks. This was recorded in the patient's notes. This ensured that people knew their rights whilst under detention of the MHA.
- The hospital provided specific administrative support within the administration team for advice and guidance around the legal requirements and implementation of the MHA.
- Responsible clinicians authorised section 17 leave appropriately. Risk assessments were completed prior to leave being granted which included an updated description of the patient. Staff recorded the outcome of the leave when the patient returned, however this did not always include the views of the patient.
- Detention paperwork was scrutinised and appeared in order.
- Patients were given information about the Independent Mental Health Advocacy (IMHA) Service. Noticeboards on the wards displayed information about the MHA and the IMHA service.
- Responsible clinicians recorded discussions with patients about consent for taking medication. Consent records matched medication records.
- The hospital recorded second opinion appointed doctor (SOAD) decisions on files for patients who lacked capacity or refused to consent to treatment.

Good practice in applying the MCA

- Eighty seven percent of staff were trained in the Mental Capacity Act (MCA).
- In the last six months there had been six DOLs (Deprivation of Liberty Safeguards) applications made to the local authority all of which had been authorised. Two had expired and urgent renewals had been applied for. One renewal was applied for on the day of inspection as the current authorisation had expired. All other DOLs authorisations were in order. DoLS assessments took into account if there was someone whom it was appropriate to consult about what was in the patient's best interest. These had been notified to the Care Quality Commission.
- Staff regularly assessed patient capacity relating to day-to-day decisions and this was recorded on patient notes.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- Staff interacted with patients in a positive way that treated them with compassion. We observed this throughout the inspection and across all wards.
- Staff were aware of individual need and specific patient preferences and were able to describe how this contributed to the care of the patients.
- Patients told us that they had good relationships with staff. However, some patients told us that the high use of bank and agency staff at night made them feel uncomfortable. This was because the staff did not know them well. We made the provider aware of these individual concerns.

The involvement of people in the care they receive

- We saw evidence that patients were given a variety of information on admission to the ward. This included information about the service and their rights if they were detained under the MHA.
- Where patients completed a person centred plan (PCP), it was clear that they had been involved in the planning and creation of their goals with the support of the advocate and with staff. However, this was not always clear in the standard care plan used by the staff. Not all patients had completed a PCP. This new process needed to be fully embedded.
- Patients had access to advocacy and this information was displayed around the wards in an easy read format that made it accessible for the patient group. Patients

took part in weekly service user forums. We saw evidence that patients were given an opportunity to provide feedback and ideas for improvement for the service.
- Family members and carers were involved in patient care. We spoke with family members and carers during the inspection and they were positive about the care the hospital gave to people. They were updated when anything changed with individual risk and were told when patient's care plans had been updated.
- The hospital provided visiting rooms for families to visit patients.

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

(for example, to feedback?)

Good

Access and discharge

- The average bed occupancy over the last 12 months for the service across all wards was 89%. The highest at 100% was on Laurel and Elm wards. The lowest at 77% was on cherry court.
- Bedrooms were available to people on return from section 17 leave.
- Care and treatment reviews had been completed for all patients. These reviews focus on the safety of the patients' care and looked towards plans for discharge from assessment and treatment services.
- Patients were admitted to the hospital from across the country and beds were funded by clinical commissioning groups.
- Patients moved wards within the hospital as part of their treatment pathway. When their independence increased, they would be moved to a ward that offered lower levels of support.
- Effective discharge planning was in place. For example when patients were ready for discharge placements near to families were considered as a priority. Staff would support patients to visit placements prior to discharge.
- A patient was discharged during the inspection and this was completed at an appropriate time. The patient was aware of all information regarding the new service and had visited previously. Prior to discharge, we saw evidence that a section 117 meeting had taken place.
- In the last six months, the service told us there had been no delayed discharges.

The facilities promote recovery, comfort and dignity and confidentiality

- There were variations across the wards in relation to the facilities and environment. On oak court some of the furnishings were tired, including rips in the material on sofas. This was immediately report to ward based staff.
- The phone on oak court was out of service and had been for over eight weeks. The provider had reported this. Patients were able to use the ward office phone in order to make calls but this meant they were not able to make phone calls in private.
- There was extensive choice for patients in relation to food and the menus changed regularly. Pictoral menus were used to support patients to make daily choices about their meals.
- Staff locked the kitchens on the wards that meant that people were not able to access hot drinks at all times. This decision was not made taking into account individual risk assessments. Patients told us that staff were responsive to unlocking the door at request. Cold water was available from water fountains.
- Access to outside space was available at times to all patients. Doors were locked and opened by staff on request. Times were limited so patients were not able to access outside space late at night or in the early hours of the morning.
- Smoking shelters were available in designated areas for patients to use and patients were able to smoke at designated times.
- There were secure areas for patients to be able to store their possessions that they were able to access themselves. A list of items patietns were not allowed to have was included in the admission pack and patients were made aware of this on admission.
- Activities were available for patients and the hospital supported the use of section 17 leave for patients to access activities in the community. Activities were provided at the weekends and were accessed by patients.

Requires improvement

Wards for people with learning disabilities or autism

Meeting the needs of all people who use the service

- Larch Ward had extra wide doorways, which meant that patients requiring a wheelchair could access the ward. The remaining wards in the hospital had made reasonable adjustments to the environment to meet Disability Discrimination Act (DDA) guidelines such as providing ramp access to wards.
- Information on treatments, local services, patient rights, advocacy and how to complain was available in reception areas and in easy read version. The service provided communication grab sheets for patients that could be used to communicate with staff when verbalisation was difficult or not possible.
- Staff accessed support from interpreters as and when required.
- The kitchen provided a comprehensive range of food to meet dietary requirements relating to either intolerances or religious requirements. Patients chose their food on a daily basis.
- There was a multi faith room available to patients but there were no examples of the room being used recently. Staff supported patients to access places of worship in the community.

Listening to and learning from concerns and complaints

- In the last 12 months, the service had recorded four complaints from external sources. This included complaints from neighbouring residents and a parent of a patient. None of the four complaints were upheld.
- Complaints from patients were managed at a local level and the manager of the service would meet with the patient to discuss the concerns in full.
- We saw evidence of a delay in dealing with one complaint, which exacerbated the situation. This did not meet the timelines set out in the hospital's policy.
- No NHS stage two complaints had been made by patients who were receiving care commissioned by the NHS. No complaints had been referred to the PHSO (Parliamentary and Health Service Ombudsman).
- Patients told us that they knew how to complain and felt comfortable doing so.
- Learning from complaints was not disseminated across the teams. For example, this was not shared across the team once information had been processed by the administration team.

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

Requires improvement

Vision and values

- The provider had a set of visions and values that applied throughout the organisation. However, staff could not tell us about them during the inspection.
- Staff knew the management team and there had been examples of the senior managers working on the wards. Patients interacted with members of the management team in a positive and friendly way.

Good governance

- Mandatory training compliance was 64%.
- Not all staff received monthly supervision or yearly appraisals. This did not meet the requirements in the provider's supervision and appraisal policy. Supervision compliance was not monitored in the service.
- Managers staffed shifts to the established levels of nurses (although these levels were at times achieved by using agency or bank staff). Staffing levels were adjusted accordingly to patient need and to support the existing staff team.
- Staff did not participate in clinical audits. This meant that there was a lack of information relating to ways the service could be improved.
- Learning from incidents and complaints was not disseminated amongst the staff team. Staff could not describe learning from incidents as this was held by the administrative team and not shared with the wider hospital team.
- MHA and MCA compliance was good overall across the service.
- There were no internal monitoring of KPI's (Key Performance Indicators) so this information was not available to the inspection team to demonstrate how the provider monitored performance. Managers told us that there were improvements being developed by the service. For example, the staff induction was under review. However, there were no specific timescales for improvements in the service to be made and some recent changes to the service were yet to be embedded fully.

Requires improvement

Wards for people with learning disabilities or autism

- Following recent changes to the management team, the registered manager was acting as the nominated individual, which meant that their capacity to run the service and support the team effectively was limited.
- A serious incident that took place at the service was not reported appropriately to the CQC as per notification requirements. The commission reviewed this issue as it is a strict liability offence however, it was not deemed proportionate to proceed in this instance.

Leadership, morale and staff engagement

- The staff 'climate' survey showed that the majority of staff felt positive about the service.
- Sickness absence rates were not made available by the service following a request prior to the inspection.
- The service had no reported cases of bullying and harassment. The management team had recently addressed a situation with a member of staff that was causing problems within the team appropriately.
- Whistleblowing information was available on staff pay slips. Some staff told us they would prefer to have a clinician as nominated contact to report concerns about the service.
- Staff told us that they would like to receive feedback from complaints and incidents.
- The regional management structure had recently been re-designed and the feedback received from staff; was that this had a positive impact on the service and the support available to them.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must take action remove or reduce the risk to patients posed by ligatures.
- The provider must take action to ensure that emergency equipment is working effectively and regular checks must be made to ensure efficiency.
- The provider must manage medication appropriately and ensure dispensing follows instructions on the prescription record. Stock must be managed effectively to ensure there are no errors.
- The provider must ensure that staff receive regular and effective managerial supervision and appraisal of their work performance.
- The provider must ensure that patients have access to clean and fit for purpose environments that promote recovery.
- The provider must report serious incidents to the CQC as required by the registration regulations.
- The provider must improve its oversight of the service by setting and monitoring key performance indicators.

Action the provider SHOULD take to improve

- The provider should monitor outcomes of serious incidents and complaints that should be shared across the hospital so lessons can be learnt.
- The provider should record and monitor the use of bank and agency staff.
- The provider should review staffing to identify any themes that have contributed to the high level of staff turnover.
- The provider should address the current mandatory training compliance rate to formulate an action plan to increase staff compliance rates.
- The provider should supply mandatory training that includes specific learning disability topics to ensure staff are equipped to care for the patient group.

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 Care and treatment must be provided in a safe way for patients. The things which a provider must do to comply include assessing the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks. We found that the provider did not mitigate to risk identified by ligature points on the ward. We found that the system in place for dispensing medication was not effective, as medications did not reconcile following spot checks. This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 12 (2) (b) (g).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises and equipment used by the provider must be suitable for the purpose for which they are being used. We found that the provider did not have effective systems for place for the maintenance of medical equipment. We found that one ward was visibly dirty and the furnishings were in poor conditions. This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (15) (1)(c)(e)(f).

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must enable the registered person, in particular, to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider did not have any key performance indicators (KPI's) to assess and monitor the effectiveness of the service. This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17 (2) (a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Care and treatment must be provided in a safe way for patients. The things that a provider must do to comply include assessing the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks. Ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. We found that staff were not receiving regular supervision or performance appraisals. This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 18 2(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Requirement notices

The registered person must notify the Commission without delay of the incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

We found that the provider had failed to notify CQC regarding a serious incident involving a patient.

This was a breach of The Care Quality Commission (Registration) Regulations 2009, Regulation 18.