

Southern Health NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

309 Cressex Road
High Wycombe, Buckinghamshire, HP12 4QF
Tel: 01865 747455
Website: www.southernhealth.nhs.uk

Date of inspection visit: 5th August 2015
Date of publication: 02/10/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW12N	Ridgeway Centre	Ridgeway Centre	HP12 4QF

This report describes our judgement of the quality of care provided within this core service by Southern Health NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Southern Health NHS Foundation Trust and these are brought together to inform our overall judgement of Southern Health NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Are services safe?	
Are services effective?	

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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Information about the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the provider's services say	7
Areas for improvement	7

Detailed findings from this inspection

Locations inspected	8
Mental Health Act responsibilities	8
Mental Capacity Act and Deprivation of Liberty Safeguards	8
Findings by our five questions	9
Action we have told the provider to take	14

Summary of findings

Overall summary

Steps had not been taken to address risks with the environment identified by the trust and highlighted in our comprehensive inspection in October 2014. Observation mirrors had not been put in place to reduce the blind spots in the unit, ligature points, such as weight-bearing curtain rails, had not been removed or the risks associated with them effectively mitigated. Bedroom doors had not been changed to anti-barricade. Despite significant ligature risks being identified at the service for more than 12 months, training in identifying and mitigating ligature risk had not been completed by half of the unit's front-line staff at the time of inspection. We requested immediate actions to be undertaken by the trust and will continue to closely monitor progress with the commissioners for the service.

The unit had recruited to a full complement of staff, and there were sufficient numbers of staff present to support people and meet their different needs throughout the day. We identified a number of minor issues, but overall there were effective systems and processes in place for the safe management of medicines. Staff received support and were debriefed following serious incidents, and reflective practice sessions formed a key part of the subsequent learning process.

Physical observations were being carried out, for example blood pressure and pulse rate checks. Patients had detailed individualised care plans on the electronic patient record system. However, support plans were not written in a format suited to individuals' different communication needs. Care records we reviewed did not reflect that patients were actively involved in writing or reviewing their care plans.

Multi Disciplinary Team (MDT) meetings were attended by a broad spread of appropriate professionals, including nurses, doctors, occupational therapist, pharmacist, and patients themselves or their representatives as required. The service had an effective MDT decision making process, with an informal and almost flat hierarchy style, whereby everyone in the team had a say and made a contribution. There was close working with other teams, including the intensive support team (IST), community learning disability team, and assertive outreach team helped to support continuity of care. Mandatory staff training was mostly up to date, and staff were able to get additional training through the trust in order to better meet the needs of people at the service.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Appropriate steps had not been taken to address known risks with the environment. Observation mirrors had not been put in place to reduce the blind spots in the unit, ligature points such as weight-bearing curtain rails had not been removed or the risks associated with them effectively mitigated, bedroom doors had not been changed to anti-barricade. Training in identifying and mitigating ligature risk had not been completed by half of the unit's front-line staff at the time of inspection.

The unit had recruited to a full complement of staff, and there were sufficient numbers of staff present to support people and meet their different needs throughout the day.

Are services effective?

Physical observations were carried out, for example blood pressure and pulse rate checks. Patients had detailed individualised care plans on the electronic patient record system.

Multi Disciplinary Team (MDT) meetings were attended by a broad spread of appropriate professionals, including nurses, doctors, occupational therapist, pharmacist, and patients themselves or their representatives as required. There was close working with other teams, which helped to support continuity of care. Mandatory staff training was mostly up to date, and staff were able to get additional training in order to better meet the needs of people at the service.

Summary of findings

Information about the service

The Ridgeway Centre is part of Southern Health NHS Foundation Trust's inpatient service for adults with learning disabilities and autism. The Centre is based in High Wycombe in Buckinghamshire, and offers assessment and treatment services primarily for adults who have learning disabilities alongside needs related to

behaviours that challenge and mental health.. It consists of a secure 20 bed mixed gender unit, but at the time of our inspection was operating with 12 beds open. All bedrooms are single en-suite. Locked doors separate male and female ward areas.

Our inspection team

The team was comprised of: two Inspectors, one Mental Health Act Reviewer (MHAR), and one Specialist Advisor in learning disabilities.

Why we carried out this inspection

In October 2014 the Care Quality Commission (CQC) carried out a comprehensive inspection of Southern Health NHS Foundation Trust (the 'trust'); this included inspection of the Ridgeway Centre. We published a report specifically relating to the core service of 'wards for people with learning disabilities and autism'. The report detailed findings for four locations; two in Hampshire, one in Oxfordshire and the Ridgeway Centre in Buckinghamshire. The report identified breaches of five separate regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Breaches of four of those regulations were found at the Ridgeway

Centre. Those regulations were: Regulation 10, Assessing and monitoring the quality of service provision; Regulation 15, Safety and suitability of premises; Regulation 23 Supporting staff; and Regulation 13, Management of medicines. CQC set compliance actions in relation to these regulations.

On 5th August 2015 we carried out an unannounced, focussed inspection to check whether the trust had met the requirements of the regulations. We had also received additional information of concern.

How we carried out this inspection

As this was a targeted inspection to follow up on specific areas of concern, we did not consider all of the five key questions that we usually ask: Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led? Instead, we concentrated on whether the service was safe and effective..

During the inspection visit, the inspection team:

- Visited all of the separate male, female and communal parts of the service and looked at the quality of the environment;

- Spoke with 6 people who used the service;
- Spoke with the Ward and Service Managers for the location and a senior representative of the trust;
- Spoke with 6 other staff members including a consultant psychiatrist, three nurses, and 2 health care assistants;
- Looked at care records, including medication records, for all of the people who were using the service at the time of the inspection;
- Carried out a Mental Health Act Review;

Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

One person told us they got to do lots of different activities, but another person said they did not get to do the activities they enjoyed doing and which they thought would support their own recovery.

People told us they had been given a tour of the building and fully informed of their rights when they first entered the service.

One person told us they did not feel comfortable speaking to some members of staff, and that they would like more frequent talk time with a trusted member of staff.

Another person told us they thought the service was nice, that they felt safe and that it was quiet at night time.

Areas for improvement

Action the provider **MUST** take to improve

- The environmental risks must be fully assessed and addressed. Until the necessary changes are made to make the environment as safe as possible, appropriate measures must be implemented immediately to mitigate effectively the risks to people using the service.

Action the provider **SHOULD** take to improve

- All front line staff should complete outstanding mandatory training to ensure they are up to date with current practice and best able to meet effectively the needs of people at the service.
- The trust stated that their incident trend analysis is monitored by the monthly Quality and Safety meetings. Therefore, data available to the trust in relation to incidents involving restraint should be reviewed further, in order to clarify whether there are any patterns or trends in need of further analysis and subsequent response.

- The book for recording of controlled drugs should be maintained in a neat and precise manner, and replaced when worn and untidy so as to minimise risk of errors. The provider should review the records and administration processes for medication to ensure they are as straightforward and effective as possible. T3 forms, used for people who are given medication without having given their consent, should be kept tidy and filed with the corresponding prescription cards.
- Charts used for monitoring of physical observations should state clearly how frequently these recordings should be made so as to avoid unnecessary staff confusion.
- The provider should ensure there is a clear process for auditing emergency equipment.
- Support plans should be clearly written in collaboration with patients and in formats which best suit each patient's individual communication needs.

Southern Health NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ridgeway Centre	Ridgeway Centre

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings as a determiner in

reaching an overall judgement about the Provider. We had a MHA Reviewer (MHAR) on the inspection team, who carried out a full, formal MHA review of the service. The findings of that review can be found in a separate report.

Mental Capacity Act and Deprivation of Liberty Safeguards

As this was a focused inspection, we did not look specifically at the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in relation to the

concerns we were following up on. However, adherence to the MCA and DoLS were assessed in the MHA Review which we carried out at the visit and those findings can be seen in the separate MHAR's report.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Appropriate steps had not been taken to address known risks with the environment. Observation mirrors had not been put in place to reduce the blind spots in the unit, ligature points such as weight-bearing curtain rails had not been removed or the risks associated with them effectively mitigated, bedroom doors had not been changed to anti-barricade. Training in identifying and mitigating ligature risk had not been completed by half of the unit's front-line staff at the time of inspection.

The unit had recruited to a full complement of staff, and there were sufficient numbers of staff present to support people and meet their different needs throughout the day.

Our findings

Safe and clean environment

- We noted that new observation mirrors had been fitted in the communal areas in response to findings at our previous inspection. However, they had not been put in place in all the blind spots in the unit, in particular the T-junctions in the patient corridors on both the male and female sides of the unit. Staff told us that the unit's budget was limited and the money available had been used to fund observation mirrors in communal areas.
- A number of significant environmental risks which could potentially impact on the delivery of safe care had been originally highlighted by the trust through its own internal checks in July 2014. This had included the identification of potential ligature points at various points throughout the unit. A ligature point is an environmental feature or structure which is load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. We found issues with ligature points had not been addressed when we undertook a comprehensive inspection in October 2014, when we identified multiple ligature risks throughout the unit. At this inspection we found that most of the ligature removal work identified by the trust and through our comprehensive inspection in October 2014 had not been carried out. We noted that some minor work had been completed such as the removal of towel holders in the en-suite bathrooms, although no safe alternative had been provided. However, most of the ligature risks identified had not been addressed and were still evident at this inspection. For example, the curtain rails posed a ligature risk, these had not been replaced and we were able to weight bear on them without them collapsing. In addition, the trust identified that the mirrors on the backs of the en-suite bathroom doors were a ligature risk. This had not been addressed at the time of our inspection on 5 August 2015.
- We were concerned that the unit's ligature risk assessment did not cover and mitigate all the risks on the unit. The unit did not have an effective way of collating risks about the environment. There was no overall environmental risk assessment, but the service had individual risk assessments of different areas in the unit. However, these were saved as electronic files and staff had difficulty finding them when we asked to see them during our inspection. We found that the unit's risk assessments for the outside courtyards (patient areas) identified ligature risks that were not identified on the separate ligature risk assessments. The courtyard risk assessments also did not identify other significant ligature risks such as locked weight bearing gate handles, and did not reflect that the courtyards were open access to patients for fresh air and that staff did not observe these areas at all times.
- The trust had carried out an internal review of the unit's environmental risks, which had been completed in July 2015 by the trust's Head of Compliance and the Quality, Performance and Business Manager for Specialised Services. The review had focused on the ligature risk assessments and judged that the Ridgeway Centre was "inadequate in dynamically managing the risks identified". The report detailed concerns that ligature risks could only be identified by the unit manager and that the staff on the unit were not aware of them. In addition, patient care plans did not reflect or consider the risks. We were shown a draft action plan, dated the 3 August 2015, produced in response to this review which detailed that staff would have ligature training and that

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

all patients would have a care plan, 'bespoke to their care needs and how the environmental and ligature risk assessments impacts on their own safety' This had a target date of 21 August 2015. We were concerned that despite being on the trust action plan dated 25 May 2015, care planning that included how environmental and ligature risks impacted on care, was not in place at the time of our visit on 5 August 2015 and was only being planned after this internal review of their progress. We found that despite ligatures being a known and significant risk at the service, training in identifying and mitigating ligature risk had not been completed by half of the unit's front-line staff at the time of inspection.

- At our last MHA visit in March 2015 we were told that bedroom doors were being altered in order to reduce barricade risks. However, since that visit only one of the doors had been changed. During our inspection visit on 5 August 2015 staff told us that prior to the identification of the doors as a barricade risk last year, a patient had barricaded themselves in their room with mattresses. We were also told about an incident where a patient had closed the door on a member of staff and assaulted them; however, fortunately staff outside the room had been able to force the door open in this instance. Information received from the trust about incidents at the Ridgeway Centre over the previous 12 months also contained details of an incident where a patient had moved the chair in their room to behind the door in an attempt to try to prevent staff from entering their room. At our inspection visit we found that the majority of bedroom doors were still not anti-barricade. Wardrobes and other furniture items were not fixed, meaning they could be placed behind doors and used to prevent doors being opened from the outside by staff in the event of an emergency. Although it is not a requirement to have fixed furniture, until our inspector raised this with the unit's staff there appeared to have been no consideration of this risk, despite staff knowing the majority of bedroom doors only opened inwards.
- In addition, there were no observation panels in the majority of bedroom doors; meaning that if a room was barricaded no one would be able to see what was happening inside the room. Staff told us that the lack of observation windows in the doors caused disruption for patients at night as they had to open the bedroom doors when they completed routine observations, and that patients complained that this disturbed their sleep.

We were shown one door that had been fitted as a trial, which appeared to be of good quality, had the ability to open both ways and which had an observation window with privacy features.

- The trust provided evidence that some patients admitted to the Ridgeway Centre posed a significant risk of harm to themselves. Following our visit on 5 August 2015, we requested and were sent information from the trust in relation to incidents at Ridgeway Centre over the previous 12 months. The information supplied to us contained records of multiple incidents of self-harming behaviour, including the use of ligatures and individuals cutting themselves while in closed bedrooms. For example, the trust's records included details on separate incidents where a patient had been found in their bedrooms with a ligature tied around their neck which had to be cut off with ligature cutters. There were also examples of patients self-harming in their own bedrooms.
- All areas accessible by staff and patients were visibly clean at the time of our inspection. The clinic room was appropriately stocked and managed, and emergency drugs and resuscitation equipment were available. Most of the nurses were trained in Immediate Life Support (ILS), and Health Care Assistants (HCAs) had Basic Life Support (BLS) training. We found some confusion between nursing staff as to how often emergency equipment such as the defibrillator was checked, and different forms for monitoring were in use.

Safe staffing

- We were assured that the unit had recruited to a full complement of staff, including four Band Six senior nurses. On the day of our visit there were nine staff on duty, of whom three were qualified nurses. Unit staff worked morning, evening and night shifts, and a ward manager and service manager worked office hours. Senior staff told us that although agency staff were used to ensure full staffing, they were all regular staff who knew the service and were familiar with the patients using it.
- At this inspection we observed that there were sufficient numbers of staff present to support people and meet

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

their different needs throughout the day. People who used the service told us there were no issues with staffing and that, for example, activities never got cancelled due to a lack of staff.

- At our previous inspection we found that improvements to staff observation were needed and, specifically, that: 'The trust should consider whether it is safe for staff to start working at the Ridgeway Centre prior to their disclosure and barring checks being in place.' At this visit we checked and confirmed that no staff were able to start working at the service now without appropriate background and occupational health checks being satisfactorily completed. A senior member of staff confirmed that occasionally a new member of staff was allowed to start without all their references being received, as long as at least one 'quality' reference had been received ; but this could only be signed off by a senior manager and on the basis that the person would be dismissed if anything negative came back from outstanding references. We saw records to confirm that all background checks had been carried out and confirmed this with the trust's personnel department.

Assessing and managing risk to patients and staff

- Patients we spoke with told us they had not personally experienced aggression from other patients or staff while at the service. Senior staff gave examples of using gentle, non-restrictive approaches to challenging behaviour, which one described as "Much more beneficial." Patients we spoke with told us they had never been restrained by staff. However, one person did raise with us they did not feel comfortable talking to certain staff. We later raised this with senior managers, and they assured us they would take action to ensure the person's concerns were addressed.
- Following the inspection we requested additional information from the trust in relation to incidents and the use of physical restraint in response to incidents and challenging behaviour. The trust's own figures highlighted potentially high use of two forms of physical restraint known as walking and seated 'Figure of Four,' in response to incidents of challenging behaviour at the service.
- We discussed safeguarding with a senior member of staff who acted as safeguarding lead for the service. They showed us the safeguarding procedure and were

able to talk us confidently through the steps that were to be taken in the event of safeguarding concerns, including which forms staff should use and how they made contact with the local authority's safeguarding team. We reviewed the training records and confirmed all staff were up-to-date with safeguarding training.

- At the comprehensive inspection, October 2014, we identified a number of issues in relation to medicines management. At this inspection we again looked in detail at the service's medicines management and practices and found the processes and systems in place to be effective overall. We did identify a single error in relation to the recording of a controlled drug, in that there was one more of a particular tablet present than there should have been according to the administration records. We raised this with the nursing staff at the time, and they agreed but were unable to explain the discrepancy. We also found the book for recording of controlled drugs was worn and untidy, which we raised with senior staff at the time and were assured it would be replaced. New charts had recently been introduced which stated the times at which each patient received their medication. We were concerned that this could lead to medication errors, and that there was potential for nurses to miss medication changes made by the prescriber. Such errors would be less likely to happen if nurses referred to the prescription cards only. We raised this with two nurses at the inspection and they shared our concern that this led to unnecessary risk of future medication errors. We also identified that T3 forms, used for people who were given medication without having given their consent, were not filed with prescription cards as they should have been and the files used for prescription cards were also untidy.
- We checked all medication and saw appropriate dosages of medicines were prescribed and administered in line with The National Institute for Health and Care Excellence (NICE) guidelines. No patients were prescribed IM (intra muscular injection) medication at the time of inspection. PRN or 'as and when required' medication was prescribed within clinical guidelines. We saw records to demonstrate that medication was prescribed in order to meet physical as well as mental health needs. Medical equipment and medicines were stored safely and appropriately, including controlled drugs. Ongoing, complete records were kept of the temperature of the fridge where

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

medicines requiring refrigeration were stored, which helped to ensure the efficacy of those medicines. The medication cupboard was neat, clean and well organised.

Reporting incidents and learning from when things go wrong

- At our previous comprehensive inspection in October 2014, we found that learning from serious incidents at the service and across the Trust's other learning disabilities services was not being disseminated effectively to staff at the Ridgeway Centre. We told the trust they 'must ensure that all staff are aware of incidents that have taken place in the service and where relevant in other parts of the trust and the learning from these incidents.'
- A senior member of medical staff stated that there were now strong links with other learning disability services within the trust, despite the geographical distance between them. They told us the trust's governance meetings adopted a process of "Could it happen here?",

and this enabled the service's staff to learn from incidents across the trust. We also saw evidence that learning from other services was shared in staff meetings.

- We saw that clinical staff based in the Ridgeway Centre were taking leads for governance work across learning disabilities services in the trust.
- We found that weekly learning and reflective practice sessions were now taking place. Nurse attendance was increased at these sessions and there was increased emphasis on sharing learning. We were told that staff got to discuss areas of practice, for example dealing effectively with challenging behaviour, and got to share what works well for them. A reflective practice session took place on the day of our inspection, following a serious incident which had taken place not long before our visit. Staff told us they had been appropriately supported and debriefed following the specific incident, and the reflective practice session was a key part of that process.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Physical observations were carried out, for example blood pressure and pulse rate checks. Patients had detailed individualised care plans on the electronic patient record system.

Multi Disciplinary Team (MDT) meetings were attended by a broad spread of appropriate professionals, including nurses, doctors, occupational therapist, pharmacist, and patients themselves or their representatives as required. There was close working with other teams, which helped to support continuity of care. Mandatory staff training was mostly up to date, and staff were able to get additional training in order to better meet the needs of people at the service.

Our findings

Assessment of needs and planning of care

- The trust used a 'track and trigger' chart for monitoring of physical observations. Out of 12 charts checked, 7 did not state how frequently these recordings should be made. We did, however, see evidence that physical observations were being carried out, for example blood pressure and pulse rate checks.
- Patients had detailed individualised care plans on the electronic patient record system. We noted, however, that the usual mode for passing on of information about patients was at the shift to shift handovers, rather than through care plans. We were told that each patient had a support plan on their unit and that these support plans were 'easy read' and for shared creation and use between patients and support and nursing staff. The support plans we reviewed were not all up to date, for example they did not have the patient's current legal status, and we found limited evidence that they were easy read or collaboratively written.

Skilled staff to deliver care

- As well as nursing staff, the multi-disciplinary team consisted of a responsible clinician, occupational therapists (OT), a speech and language therapist and

psychologists. General healthcare was commissioned via a private contract with a private medical company. A pharmacy technician visited the unit weekly and the trust pharmacist visited monthly.

- At the comprehensive inspection undertaken October 2014, we found that staff (support workers in particular) identified a need for more training to help them meet service users' needs, for example training in autism, learning disability, mental health, communication and personality disorder. We requested that the trust must ensure that all staff, including support workers, had training to enable them to meet the specific needs of people using the service. At this inspection, we found the trust had taken sufficient steps to address, overall, the concerns raised previously. We reviewed staff's training records with an appropriate senior member of staff and saw that most mandatory training was up to date. Staff who were due or overdue specific training were identified through a traffic light system, so that the management could ensure everybody's training remained valid. Dates had been set for staff to complete outstanding training in topics such as infection control, health and safety and medicines management. Staff told us they were able to get additional training through the trust, if requested, in specialist topics such as understanding autism and conflict resolution, in order to better meet the needs of people at the service. A member of staff told us they had requested to attend local authority safeguarding training and this had been agreed to.

Multi-disciplinary and inter-agency team work

- Multi Disciplinary Team (MDT) meetings were attended by a broad spread of appropriate professionals, including nurses, doctors, occupational therapist, pharmacist, and patients themselves or their representatives as required. A senior member of medical staff told us about effective multi-disciplinary and inter-agency team-work, and described an effective MDT decision making process. They used an informal and almost flat hierarchy style, whereby everyone in the team had a say and made a contribution. Close working with other teams, including the Intensive Support team (IST), Community Learning Disabilities team, and Assertive Outreach team helped to support continuity of care.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 HSCA (RA) Regulations 2014: Safe Care and Treatment

The registered person did not demonstrate that care and treatment was provided in a safe way for service users. They had not effectively assessed and mitigated the risks with the environment, such as the risk from ligature points. They had not ensured the premises are safe for their intended purpose or used in a safe way.

This is a breach of regulation 12(1) & (2)(a),(b)&(d)