Fairview

Quality Report

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Date of inspection visit: 6 July 2017
Date of publication: 19/09/2017

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services well-led?	

Overall summary

From our inspection we found:

- Patients were not always monitored in line with the provider's policy after receiving rapid tranquilisation.
- Some risk assessments had not been updated within the provider's timescales. This included assessments for patients with epilepsy and at risk of choking.
- Handover discussions took place in environments which made it difficult to convey information effectively. Rooms were small and there was a lack of other facilities.
- Some handovers took place in communal areas which lacked confidentiality and did not maintain patients' privacy and dignity.
- Care records were difficult to navigate and it was difficult to access information about patients quickly. Some care plans had not been updated in line with the provider's own policy.
- There was no systematic monitoring of physical healthcare for those patients receiving high doses of antipsychotic, antidepressant and anticonvulsant medication.
- The provider did not demonstrate that it was following NICE guidance for challenging behaviour and antipsychotic medication by identifying target behaviours and stopping at six weeks if there was no response.
- As required medication protocols were not individualised and lacked clarity.

Summary of findings

- Mental capacity assessments were not person centred, did not evidence family involvement and did not show how decisions had been reached in relation to patients' capacity.
- The provider had not conducted an audit of positive behavioural support plans to ensure their quality and that they had been updated regularly.
- Six carers said that communication from the hospital was minimal, poor or inconsistent and that they often had to ring the hospital to get information about their relative.

However:

- Restraints across the hospital had reduced since the last inspection in February 2017, showing a downward trend.
- The provider ensured patients had a behavioural support plan and had taken steps to put this approach at the centre of its care planning. Staff received training and the psychologist and behavioural therapist offered support to staff on the wards.
- Staff were caring and treated patients respectfully and showed understanding of patients' needs.
- The provider had developed a robust and clear system to monitor the performance of staff and the hospital through key performance indicators.
- The provider had appointed a safeguarding lead to ensure the quality and timeliness of safeguarding information to the local authority, police and the CQC.

Summary of findings

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Summary of this inspection

Background to Fairview

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 CAS Learning Disabilities Limited and the corporate provider is Cambian Healthcare Limited.

The hospital can accommodate up to 63 patients. 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 behaviours
- 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, used by patients across all wards.

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.

The Care Quality Commission previously carried out a comprehensive inspection of this location from the 21st to 27th February 2017. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for regulation 12, safe care and treatment. The provider sent the CQC their action plans to address these.

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 one CQC inspector, two inspection managers, a nurse and a doctor, who work with the CQC as specialist advisors.

Why we carried out this inspection

We carried out a focused inspection of this location in response to concerns identified by the Care Quality Commission in relation to restraints, injuries and medication. The inspection focused on four domains, safe, effective, caring and well-led. The inspection focused on three wards, Elm Court, Larch Court and Redwood Court. As a result of the nature of this inspection, we have not included ratings for the hospital as a whole.

Summary of this inspection

How we carried out this inspection

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

During the inspection visit, the inspection team:

- visited three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with 13 carers of patients
- spoke with the registered manager and deputy manager, and acting managers for each of the wards
- spoke with 11 other staff members; including doctors, nurses, psychologists and healthcare assistants
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management on three wards 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 two patients but were not able to get any detailed feedback about the hospital.

We spoke to 13 carers of patients. Nine were positive overall about the hospital and how they had cared for their relative and four were negative. Six carers said that communication from the hospital was poor or non-existent and several said they had to contact the hospital themselves to get information. One carer said that they did not always get told when there had been an incident involving their relative. Another carer said that they sometimes received contradictory accounts of what had happened. Others said communication had improved but was inconsistent. Six carers said that they received regular updates about their relative and were happy with the way the hospital communicated with them.

Carers were pleased with the way most staff treated them and their relative. 10 out of 13 carers said that most staff were polite, caring and respectful, and spoke very positively about how staff interacted with them. However, six carers said that some of the staff were rude or unhelpful. Three carers stated that although there were some good staff, their overall experience of the staff at Fairview was negative.

Carers raised issues about the activities their relatives were able to access. Six carers said that their relative did not have enough to do. One said that there was little on offer apart from television, meaning that their relative often had little to do and took little exercise. Four carers said they were happy with the amount and variety of activities on offer.

Carers were also concerned about some specific issues. Four said that their relative had put on a lot of weight since coming to Fairview, and one that their relative had lost weight. Two carers said that they had seen their relative dressed in other patients' clothes and had complained to the hospital about this.

Ten carers also spoke about how they had been involved in care planning. For some this involvement was thorough and meaningful, while others felt that staff did not listen to what they said. One carer said that she told staff information they had already shared when information was being gathering on admission but that staff were unaware of this. Two carers said that they had not been involved at all and one of these said that they did not feel there was much in the way of a treatment plan.

Seven carers mentioned that their relatives were prescribed high levels of medication and that this was an important issue. Four carers were concerned that high levels of antipsychotic medication were maintained but that there was no improvement in the patient's symptoms or behaviour. Carers commented that medication did not reduce as planned, that it was not reviewed and that drugs were prescribed to control aggressive behaviour.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

From our inspection we found:

- Patients were not always monitored in line with the provider's policy after receiving rapid tranquilisation.
- Two risk assessments had not been updated within the provider's timescales. This included assessments for patients with epilepsy and at risk of choking.
- There were insufficient details in one patient's notes about how to care safely for someone at risk of choking.

However:

- Restraints across the hospital had reduced since the last inspection in February 2017, showing a downward trend.
- Staff received training on how to restrain patients safely and we observed staff using de-escalation techniques appropriately.
- Staff made safeguarding referrals appropriately to the local authority.
- The provider had systems in place to ensure that staff learned from incidents.
- Staff reported incidents through the provider's incident reporting system.

Are services effective?

From our inspection we found:

- Handover discussions took place in environments which made it difficult to convey information effectively due to the small size of the nursing offices and the lack of other facilities.
- Care records were difficult to navigate and it was difficult to access information about patients quickly.
- We found examples of care plans which had not been updated in line with the providers own policy.
- There was no systematic monitoring of physical healthcare for those patients receiving high doses of antipsychotic, antidepressant and anticonvulsant medication.
- There was still no system in place to ensure that all electrocardiogram and blood test results were kept in patient files.
- The provider did not demonstrate that it was following national institute for health and care excellence guidance for challenging behaviour and antipsychotic medication by identifying target behaviours and stopping at 6 weeks if there was no response.

Summary of this inspection

- As required medication protocols were not individualised and lacked clarity.
- There was a lack of clarity concerning some medical interventions. One prescription for covert medication was not sent to the pharmacy for over four months and did not specify how to dispense the medication effectively.
- Mental capacity assessments had been completed but were not person centred, did not evidence family involvement and did not show how decisions had been reached in relation to patients' capacity.

However:

- Consent to treatment forms were available to inspect and had been completed correctly.
- New staff received positive behavioural support training as part of their induction. The provider told us they planned to extend this to all staff.

Are services caring?

From our inspection we found:

- Staff were caring and treated patients respectfully.
- Staff showed understanding of patients' needs.
- Most carers said that they had been involved in care planning and were happy with the treatment their relative was receiving.

However:

- We saw one patient supported in a way that did not maintain their privacy or dignity.
- Two carers stated that they had raised issues with the hospital in relation to their relatives wearing other patients' clothes.
- Six carers said that communication from the hospital was minimal, poor or inconsistent and that they often had to ring the hospital to get information about their relative.

Are services well-led?

From our inspection we found:

- The provider had developed a robust and clear system to monitor the performance of staff and the hospital through key performance indicators.
- The provider had changed the way Mental Health Act and Mental Capacity Act training for staff was recorded and had planned regular updates for staff.
- The provider had appointed a safeguarding lead to ensure the quality and timeliness of safeguarding information to the local authority, police and the CQC.

Summary of this inspection

- The provider had ensured all patients had a positive behavioural support plan. New staff received training in this as part of their induction. Staff were supported through psychology and behavioural therapy support on the wards.

However:

- Not all staff had been trained in positive behavioural support. Support plans were not always comprehensive and varied in quality.
- Managers had not ensured the quality of mental capacity assessments. We found that several assessments contained identical wording and were not personalised. We raised this with the provider during the inspection and they took steps to address this.
- The provider had not conducted an audit of positive behavioural support plans to ensure their quality and that they had been updated regularly.
- Managers had not ensured that patient records could be quickly and easily navigated to ensure that staff were able to support patients safely and effectively.

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe staffing

- There were sufficient staff on the wards to support patients safely. Staff prioritised work with patients, including activities and time patients spent with their named nurse. We spoke to ward staff and managers who confirmed that wards had enough staff to ensure patients could have leave, including those who required two staff to support them in the community.
- Doctors covered their own units after 5pm and attended wards in an emergency. At weekends, the hospital used an on-call system based in Birmingham (about 150 miles away). Staff dealt with physical health issues by calling 111 or 999.

Assessing and managing risk to patients and staff

- Staff completed risk assessments for patients. They also completed daily risk assessments and recorded actions they had taken. However, one risk assessment referred to a patient at risk of choking who had undergone an assessment by a speech and language therapist. This assessment was not recorded in the patients' health action plan and we were unable to locate a swallowing assessment or a care plan relating to how this should be managed. We found an example of a risk assessment for a patient with epilepsy which was completed by an occupational therapist and had not been reviewed or updated within the provider's timescale.
- Across the hospital there were 191 incidents of restraint between April 1st and 30th June 2017. Between 1st December and 28 February this figure stood at 287 incidents. This represents a downward trend. Staff we spoke to said that they only used restraint as a last resort and used de-escalation techniques to try to defuse situations. Incident forms gave details of de-escalation techniques being used. We observed staff working with patients on Redwood Court using de-escalation to avoid restraining a patient. A nurse described how physical interventions could make things worse and how they would try other strategies first. Staff received restraint training in the management of actual and potential aggression.
- Staff made safeguarding referrals appropriately to the local authority.
- Patients were not always monitored in line with the provider's policy after receiving rapid tranquilisation. After one incident, no physical observations were recorded in the monitoring form; however, the patient's current behaviour was recorded.
- The provider stated that seclusion did not take place at the hospital. We spoke to two nurses who were knowledgeable about seclusion and were clear that they did not seclude patients. However, one nurse was not confident that all healthcare assistants were aware of when seclusion could potentially take place. Staff said that if a patient continued to be disturbed they would clear others from the area to ensure their safety.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents through the provider's paper incident reporting system. Incident forms we looked at contained detailed information.
- Staff learned from incidents via monthly team meetings, supervision, de-briefs and the daily morning meetings. The five most recent areas of learning were displayed on notice boards throughout the hospital.

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

Assessment of needs and planning of care

- Care records were difficult to navigate and contained significant duplication of documents. We looked at

seven care records and found assessments and care plans were duplicated and there was a high number of folders, making it difficult to access relevant information about patients quickly. This meant that staff might not be able to get the information they needed to support patients effectively.

- Assessments and care plans had been completed in all of the records we looked at. However, we found examples where these had not been reviewed in line with the provider's own review date. All patients had positive behaviour support plans, which had been printed out and kept in grab folders on each ward so staff could read and refer to them. These contained some description of a patient's behaviours and looked at strategies to reduce these. They also gave brief details of how a patient's behaviour could change, including "triggers" that might make things worse and strategies to manage different behaviours, including some de-escalation techniques. However, these were not always comprehensive or detailed. We observed staff on observations familiarising themselves with these plans. Plans contained sensory interventions consistent with patients' autistic and sensory needs, although we found some examples where plans were brief. Positive behavioural support plans had not been audited and we found an example where they had not been reviewed with the timescale set by the provider.

Best practice in treatment and care

- There were some high levels of antipsychotic prescribing for three patients on Larch Court and Redwood Court. We looked at seven care records and 14 prescription charts. This included two patients who were prescribed medication above the maximum dose recommended by the British National Formulary. These were within the limits set by the second opinion appointed doctor. However, antipsychotic medication was often prescribed for aggression and agitation, and there was little evidence of this being reviewed regularly to ascertain if the medication had been helpful. The provider did not demonstrate that it was following NICE guidance for challenging behaviour and antipsychotic medication by identifying target behaviours and stopping at six weeks if there was no clinical improvement or benefit for the patient. This meant they were not following best practice guidelines.
- There was no systematic monitoring of physical healthcare for those patients receiving high levels of antipsychotic medication and for those on antidepressant and anticonvulsant medications. We found that one patient had very low sodium levels requiring regular monitoring and it was not clear from the records that this had been addressed.
- There was not a clear process in place to ensure that staff had timely access to electrocardiogram and blood test results. These are kept at the GP practice. This issue was raised in the last inspection report and the hospital provided an action plan to show how they would deal with this issue. The provider had appointed a nurse to provide a physical health focus on Larch Court initially. However, it was not known how physical health monitoring was going to be introduced across the hospital long term.
- As required medication (PRN) protocols were not always individualised and lacked clarity. We found that there were identical descriptions of behaviours for two patients requiring additional medication. One patient had two different as required medications prescribed, with no rationale as to which medication should be administered in a given situation.
- There was a lack of clarity concerning some medical interventions. We found a prescription dated in December 2016 for covert medication for a patient, which was not sent to the pharmacy for over four months. The pharmacist did not take part in multi-disciplinary team meetings and had not specified a suitable method to dispense the medication effectively.

Skilled staff to deliver care

- Positive behavioural support training was provided by a psychologist and behaviour therapist, who were keen to develop and consolidate this within the hospital and wider organisation. Training was offered at induction and the provider stated that they had plans to deliver training to all ward staff. The behaviour therapist attended handovers and had piloted a new format for the support plan. However, positive behavioural support plans still emphasised reactive strategies.
- Staff we spoke to were knowledgeable about this and gave details of how they would promote positive behaviours with complex patients.

Multidisciplinary and inter-agency team work

- The effectiveness of handovers was compromised by the lack of dedicated space in which to conduct the

meetings. They did not enable staff to have a clear overview of what had happened on the previous shift and make effective plans for the oncoming shift. We observed handovers on Elm Court, Larch Court and Redwood Court which involved all staff from the on-coming shift. On Larch Court and Redwood Court, handovers took place in the nursing offices. On Larch Court, this was too small to accommodate all the nursing staff, so most stood outside in the corridor. This made it difficult to hear what was said and to contribute to any discussion. On Elm Court, the handover was held in a communal lounge and lasted for 15 minutes. During the meeting staff talked over each other, making it difficult to hear what was being said. The nurse in charge reviewed the presentation of each patient overnight, including highlighting risk issues and self-injurious behaviours. Information was shared with staff about relevant issues from the previous shift, together with some plans and appointments for the day shift. Handovers took place twice a day on all the wards and were documented.

- Handovers briefly discussed issues relating to individual patients and events on the previous evening and night shifts. On Redwood Court, tasks were identified and allocated for the oncoming shift. However, information passed over was not sufficiently detailed for the member of staff who did not work regularly on this ward.
- On Elm Court, the handover was held in a communal lounge. The lack of a dedicated space for handover meant that the meeting was interrupted twice by patients trying to access the communal lounge, and were removed by staff. This demonstrated a lack of dignity, privacy and confidentiality and had a significant impact on patients.
- The psychologist attended handovers on the wards on a regular basis throughout the week.
- The hospital worked effectively with local authority teams and arranged for care programme approach and community treatment reviews to take place.

Adherence to the MHA and the MHA Code of Practice

- All medication records we looked at demonstrated that consent to treatment forms were routinely available to inspect and had been completed correctly. Staff administered medication as indicated by T2 or T3 paperwork, which meant the medication patients received was authorised by an approved doctor. 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 he or she needs or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.

Good practice in applying the MCA

- Mental capacity assessments were not person centred and did not demonstrate how or when capacity was assessed. We looked at seven care records. Staff completed day-to-day decision forms (MCA1 forms) and were generic in nature. We compared three patients' records and found that most of the mental capacity assessments were not personalised and contained identical wording, including descriptions of patients' views. Assessments were undated, lacked evidence of family involvement and did not show how decisions had been reached in relation to patients' capacity. One mental capacity assessment detailed clearly the discussion with the patient, how the assessment had been made and how the decision had been reached.

Are wards for people with learning disabilities or autism caring?

Kindness, dignity, respect and support

- We spent time on each of the three wards and observed staff treating patients kindly and respectfully. They took time to give emotional support and showed an understanding of patients' needs. However, we also observed one interaction during a handover on Elm Court, held in a communal lounge, where a patient who was not fully dressed, entered the room. He was immediately surrounded by three staff members, grabbed by the elbows and escorted out of the room. No verbal prompts were used. Staff did not deal with this sensitively and did not afford the patient dignity and privacy.
- Staff demonstrated they had good knowledge and understanding of patients' needs and how best to interact with them.

Wards for people with learning disabilities or autism

- Two carers stated that they had raised issues with the hospital in relation to their relatives wearing other patients' clothes.

The involvement of people in the care they receive

- There was some active involvement of patients in personal behavioural support planning but this was not well documented. We looked at seven patient records and spoke to 13 carers. 10 carers said that they had been involved in care planning for their relative. Three carers said they had not been involved or that the provider had they had needed to be persistent to ensure their involvement.
- Nine carers were positive about the hospital and four were negative, although one carer was positive about one of the wards their relative had stayed on and very negative about another. Four carers said that communication was poor and that they were not routinely given updates on their relatives' progress and had to ring to get this. Two others said that communication was limited and did not give sufficient information. Three carers said their calls were not always returned and that it was difficult to speak to the psychiatrist.

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

Good governance

- Since the last inspection, the provider had developed an effective system to monitor hospital processes and performance through key performance indicators. This included training, appraisals, supervision, incidents and staffing. These were easily accessible and in a clear format. However, information about patient care was not always readily available. We requested information about how often a patient was able to access leave in the community, but the provider was not able to provide this.
- The provider did not have a robust system for monitoring patients' physical health. A nurse had been appointed to ensure the provider complied with the regulations, but was not yet in post.
- Mental Health Act and Mental Capacity Act training was no longer part of a larger e-learning induction programme and could be reported separately. The provider also planned to give regular updates to staff rather than confine this to induction training.
- The provider was aware of the difficulty in accessing information about patients quickly and had started to review how they recorded and stored information in patient records.
- Staff reported safeguarding incidents appropriately. The provider had appointed a safeguarding lead to oversee information sharing concerning incidents and investigations, including the quality and timeliness of information provided to the local authority, police and the CQC. Safeguarding information provided to the CQC had improved since the last inspection in February 2017.
- The provider had promoted positive behavioural support across the hospital. All patients had a support plan and new staff received training in this as part of their induction. Staff were also supported in this area through psychology and behavioural therapy support on the wards. However, not all staff had received training and positive behaviour support plans were not comprehensive and varied in quality. Managers had not yet conducted an audit of these plans.
- Managers had not ensured the quality of mental capacity assessments. We found that several assessments contained identical wording and were not personalised. We raised this with the provider during the inspection and they took steps to address this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all patients who receive rapid tranquilisation are monitored in line with NICE guidelines and the provider's own policy.
- The provider must ensure that NICE guidelines are followed in relation to antipsychotic medication and challenging behaviour for patients with learning disabilities.
- The provider must ensure there are systems in place for electrocardiogram and blood test result to be kept on site.
- The provider must ensure that it has suitable dedicated space for staff to conduct handovers effectively.
- The provider must ensure that dignity of patients is not breached in handovers.
- The provider should ensure that mental capacity assessments are person centred and demonstrate how and when capacity was assessed and, where appropriate, how decisions were reached in patients' best interests.

Action the provider SHOULD take to improve

- The provider should ensure that all risk assessments and care plans are reviewed and updated in line with the provider's policy.
- The provider should ensure that staff can access patient care plans easily and that these plans clearly document how staff should support patients.
- The provider should ensure that prescriptions for as-required medication for patients are detailed, clear and individualised.
- The provider should ensure that handovers are held in a suitable environment where all staff can hear and participate in discussions concerning patient care.
- The provider should ensure that they communicate effectively with carers and give regular updates, after discussion with patients where appropriate.

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 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider had not ensured that they could conduct handovers between shifts that protected patients' privacy, dignity and confidentiality. **This was a breach of regulation 10**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The provider had not ensured that mental capacity assessments were person centred and demonstrated how and when capacity was assessed and how decisions were reached in patients' best interests. **This was a breach of regulation 11**

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 • Staff did not always ensure that patients were being monitored in line with guidance after receiving rapid tranquilisation medication.

This section is primarily information for the provider

Requirement notices

- The provider had not demonstrated that where patients had been prescribed high doses of antipsychotic medication, they had been reviewed in line with national institute for health and care excellence guidance.

- The provider did not have a system in place to ensure that they had timely access to electrocardiogram and blood test results in patients' notes.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises • The provider had not ensured that there was sufficient dedicated space to conduct handovers effectively. **This was a breach of regulation 15**