

Review of compliance

Castlebeck Care (Teesdale) Ltd

Region:	South West
Location address:	Winterbourne View. Vantage Park, Old Gloucester Road, Bristol, BS16 1RS.
Type of service:	Independent Healthcare Provider.
Publication date:	July 2011.
Overview of the service:	<p>Castlebeck Care (Teesdale) Ltd was registered with the Care Quality Commission on the 1 October 2010 (they were previously registered under Care Standards Act 2008).</p> <p>Winterbourne View is a 24-bed purpose designed Assessment and Treatment Unit in South Gloucestershire operated by Castlebeck</p>

	<p>Care (Teesdale) Ltd.</p> <p>It is an independent provider of healthcare and support for adults with learning disabilities, complex needs and challenging behaviour, including those liable to be detained under the Mental Health Act 1983.</p> <p>The premises are laid out over three floors. The ground floor accommodates the main office, a kitchen, and laundry and meeting rooms. The middle floor is for people who are being aided with their rehabilitation. This is in order that they may move out of Winterbourne View into a more independent living type accommodation. The top floor accommodation is for people with more complex needs who require intensive input and support from staff.</p>
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Summary of our findings for the essential standards of quality and safety

What we found overall

We found that Winterbourne View was not meeting 10 essential standards. We have serious concerns about this service and have taken enforcement action to remove Winterbourne View from the registration of Castlebeck Care (Teesdale) Ltd

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

On 12 May 2011, CQC was informed that the BBC television programme Panorama had gathered evidence over several months to show serious abuse of patients at Winterbourne View.

A multi-agency safeguarding meeting was held on 13 May to include some of the 10 NHS organisations and councils who were commissioning care from Winterbourne View, along with the safeguarding authority, South Gloucestershire Council, the police and CQC. The same day, we met with the provider Castlebeck Care Ltd, to seek assurances that all new admissions would cease until all investigations were completed. The provider gave verbal assurances and told us that while investigations were completed in relation to the safeguarding information that had been received they would cease admissions to Winterbourne View with immediate effect. This was followed up in writing by the provider. We sought further assurances from the provider to ensure the continued suspension of new placements on Monday 23 May 2011. By 18 May the provider had suspended 15 staff and arrangements were made to bring in temporary staff to provide additional cover.

While the immediate priority for all agencies was to ensure the safety and welfare of the people living there, CQC also considered whether to take further action under the Health and Social Care Act 2008. We carried out this review to look in greater detail at the standards of care at Winterbourne View, and to report on their systems to protect the safety and welfare of the people who were using this service.

We carried out this responsive review because serious concerns were identified in relation to eight aspects of the essential standards of quality and safety:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Management of medicines
- Requirements relating to workers
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaints
- Records

How we carried out this review

As part of this review we decided to follow up the specific information provided by the television reporter and the whistleblower, to examine the care provided to people and the safeguarding and governance systems which were in existence at Winterbourne View. The television report provided clear evidence which was not available from other sources, but we needed to corroborate that by referring to the hospital's own records, and speaking to staff and patients directly.

We examined all of the information we held about this provider. On 17, 18, and 24 May and on 2 June 2011, we carried out site visits at Winterbourne View. We observed in detail how people were being cared for, we talked with 10 people who used the service, we talked with 25 members of staff, we checked the registered provider's records, and we looked at the records of the people who used the services provided at Winterbourne View. We also spoke with the manager and regional director. We also returned to Winterbourne View on 20 May in order to collect further documentation that we had requested.

As set out above, following the receipt of information detailing significant and safeguarding allegations on 12 May 2011 we attended a multi agency safeguarding strategy meeting, on the 13 May 2011. Subsequent multi agency safeguarding meetings have been held and attended by us on 20 May 2011 and 6 June 2011.

Having considered all the available information, we concluded that:

- The registered provider, Castlebeck Care (Teesdale) Ltd, had failed to ensure that each person living at Winterbourne View was adequately protected from risk, including the risks of unsafe practices by its own staff. The registered provider did not take proper steps to ensure that people who use the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe as the planning and delivery of care did not meet people's individual needs.
- The registered provider did not protect the people who use this service against the risks of unsafe care and treatment due to the ineffective operation of systems. The registered provider did not have robust systems to assess and

monitor the quality of services provided in the carrying on of the regulated activities.

- The registered provider did not identify, assess or manage risks relating to the health, welfare and safety for the people who use this service. The registered provider had not responded to complaints and comments made and had not considered the views, including the description of their experience of care and treatment, expressed by people who use the service, and those acting on their behalf.
- Investigations carried out by the registered provider into the conduct of persons employed at Winterbourne View were not robust and had not safeguarded people.
- The registered provider did not take reasonable steps to identify the possibility of abuse and prevent it before it occurred; and did not respond appropriately to allegations of abuse. Where a form of restraint was used the registered provider did not have suitable arrangements in place to protect the people who used this service against the risk of control or restraint being unlawful or otherwise excessive.
- The registered provider did not operate effective recruitment procedures and did not take appropriate steps in relation to persons who were not fit to work for the purpose of the regulated activity, for example by failing to inform the appropriate regulatory or professional body.
- The registered provider failed in relation to their responsibilities by not providing the appropriate training and supervision to staff, which would be required to enable them to deliver care and treatment to the people who use the service.

During the course of this review, CQC considered whether it would be appropriate to seek the urgent closure of Winterbourne View. We needed to ensure that any action took into account the needs and best interests of the patients, and after consultation with all the other agencies it was clear that the NHS primary care trusts, who are responsible for commissioning the care for individuals, needed further time to review their needs and find alternative placements so that people could be moved in a planned and positive way. We were satisfied that the short term specialist support arrangements agreed by the commissioners and providers would ensure the safety and wellbeing of the remaining patients, and we received further assurances from the provider on the suspension of admissions.

What people told us

The people who live at Winterbourne View had been assessed as having learning disabilities, complex needs and challenging behaviour. They have varied methods of communication, some people were able to express their views clearly and others could not. A short observational framework for inspection (SOFI) was undertaken in order to establish, for a small number of people, what their experience of living at Winterbourne View was like. The observation took place on the middle floor of the hospital and took place on the first day of our visit, 17 May 2011.

During our visit on 17 May 2011 one person approached us and when we asked them about their medicines commented that they were happy with how their medicines were given to them.

Also during this visit a person showed us their room and took pride in showing us photographs of their family. They named one member of staff and told us that they had a good relationship with this person, they told us; "He is alright, I get on with him ok".

In total we spoke to ten people who lived at Winterbourne View in order to establish if their comments and complaints were listened to and acted on effectively. Three of the people we met and talked to at the hospital said that they would talk to a member of staff or to the manager if they had a complaint. Two other people told us that they would tell their relatives or friends if they had a complaint as this would be listened to.

What we found about the standards we reviewed and how well Winterbourne View was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

The people who used the service at Winterbourne View did not receive effective, safe and appropriate care, treatment and support that met their needs and protected their rights. This is because the quality of information recorded within care plans was poor and not person centred. There was a lack understanding of the complex needs of people and the planning and delivery of care and treatment did not ensure the welfare and safety of people.

Injuries to people using the service and subsequent accident reports were not followed up. Records evidenced a lack of prompt medical attention, including a lack of wound management and a lack of support and intervention to prevent self harming or attempts by people to take their own life. Proper steps were not taken to ensure each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe

Outcome 7: People should be protected from abuse and staff should respect their human rights

The registered person had not made suitable arrangements that were effective to identify and prevent abuse from happening. They had not responded appropriately to allegations that abuse had occurred or was at risk of occurring to ensure people were protected. Therefore the people, accommodated at Winterbourne View, were not fully protected from abuse, or the risk of abuse.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

The registered provider did not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The registered provider did not operate effective recruitment procedures and did not take appropriate steps in relation to persons who were not fit to work for the purpose of the regulated activity, for example by failing to inform the appropriate regulatory or professional body.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People who used this service did not have their needs met by competent staff. Supportive structures for staff, such as supervision, core and specialist training were lacking, causing concern for the ongoing safety for people who reside at this location.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People who used the service at Winterbourne View did not receive safe, quality care, treatment and support, due to ineffective decision making and poor management of risks to their health and safety. There was a lack of leadership and management and ineffective operation of systems for the purposes of monitoring of the quality of service that people receive.

Outcome 17: People should have their complaints listened to and acted on properly

The registered person did not have in place an effective system for identifying, receiving and handling complaints. Complaints were not investigated robustly and people were not supported to make complaints.

Outcome 19: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983

The registered person did not ensure that important events that affected the welfare, health and safety of people who used this service were reported to the Care Quality Commission as required and to support action taken to keep people safe. .

Outcome 20: Notification of other incidents

The registered person did not ensure that important events that affected the welfare, health and safety of people who used this service were reported to the Care Quality Commission as required and to support action taken to keep people safe.

People who live at this service are not looked after by staff that are appropriately managed and lack clear lines of staff accountability.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The registered person did not ensure that the people who used this service were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

Accurate records were not maintained in respect of the care and treatment provided. Other records in relation to staff employed and the management of the regulated activities carried out at Winterbourne View were also not appropriately maintained.

Action we have asked the service to take

We agreed with the registered provider Castlebeck (Teesdale) Ltd that they would not accept any further admissions into the service, and this came into effect on Friday 13 May 2011. This was to ensure that people living at Winterbourne View were not placed at increased potential risk of harm and to also ensure that any new admissions are not placed at any potential risk of harm.

We were aware that there were safeguarding concerns for some people who lived at Winterbourne View and we continued to monitor the continuing care and welfare of the people who remained at Winterbourne View in close consultation with South Gloucestershire Council and NHS South Gloucestershire.

Due to the major concerns identified as a result of this review we took enforcement action to remove the location from the provider's registration. The provider will not be registered to provide regulated activities from this location. The provider did not lodge any appeal against this enforcement action.

Other information

Please see previous review reports for more information.

What we found
for each essential standard of quality
and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4: Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are major concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

Evidence reviewed from the site visits confirmed that the people who used this service did not experience effective, safe and appropriate care, treatment and support to meet their needs.

During our visit to Winterbourne View we completed a short observation on the middle floor. We observed five people over a one hour time period, recording our observations every five minutes. During the observation four staff members were seen supporting people to engage in a discussion activity. We also observed people in the lounge and in the communal areas of this floor. The people we observed engaged with staff in a positive manner, people were calm and relaxed. We saw the staff interacted with people in a polite and clear way, no concerns were noted by us during this observation.

During our visit on 18 May, we asked to see care plans for one patient who had a history of self harming. In the first three months of 2011, she had either injured or harmed herself on 10 occasions. For all of those injuries, no wound care plans were in place, and there were no records of how wounds would be dressed, treated and monitored in order to promote skin repair and reduce the likelihood of infection.

The risk assessment recorded that she had a history of self harming and threats to

commit suicide. It rated the probability of harm as "inevitable" and recorded the steps to reduce the opportunity for a harmful event, but it did not include all areas of risk, for example, risks of attempting to commit suicide or self harm by the use of ligatures and jumping out of windows, which the person had attempted to do. These risks had not been assessed and safety measures not put in place. Reactive measures were recorded as "access injury; administer appropriate first aid, and all staff to be first aid trained." Only nine of 53 staff had completed emergency first aid training.

We were given a copy of an 'identified risks care plan' for 'knee dislocation during restraint,' (completed on 29 August 2009) which included a requirement that the nurse in charge would decide whether the person should attend hospital if a knee dislocation occurs. However, it also said that "hospital staff had advised not to bring the person to hospital as there is limited assistance they can provide due to ongoing knee problems". There was no explanation for this inconsistency.

A 'person specific care plan' dated 29 May 2009 identified that the objective of the plan was for this person to learn relaxation techniques and develop a 'good night time routine', but there were no examples of 'relaxation techniques', what this involved and the benefits for the person. Incident reports for this person were incomplete or contained information of variable quality with no evidence that the planning and delivery of care met her needs.

It was apparent that even though this person had a long history of injury, the service had not anticipated all obvious risks and considered only basic information on dealing with such incidents when they did arise.

When we reviewed the information recorded within the incident reports for the same person we saw that the recording of information was of variable quality and not all areas of the reports had been completed to give full information for review and consideration. Records showed action was not taken to prevent injuries or wound care plans put in place to support their care. This did not evidence assurances that the planning and delivery of care met the needs of this person.

For a second person we reviewed accident records and saw that when self harming had occurred it was often the person themselves who reported this to the staff on duty. Strategies for the prevention of injuries or harm recorded in the care records lacked detail to support staff to minimise the risks. We reviewed records that identified these accidents and the range of items the person had used to self harm. No wound care plans were in place and although the incidents were frequent and repetitive and similar in nature proactive steps had not been taken through a care planning process to reduce access to harmful objects.

During our review of documentation we found that risk assessments were not reviewed or updated following serious incidents; we found many examples of these including:

On an incident form dated 4 April 2011 a person who lived at Winterbourne View spat in the face of another person who also lives there and was then slapped in the

face as a result. The statement form recorded that one of the people was held by staff using 'hooks and cradles'. These techniques were not documented in their physical intervention risk assessment to guide and inform staff.

We saw an incident form for one person dated 18 March 2011 in which they are described by staff as being 'abusive'. They were 'sent' to their bedroom for time-out when it was reported that this person had upturned furniture in their room. The risk assessment was not updated following this incident.

An incident form for another person dated 2 March 2011 records that they were restrained using 'Maybo' techniques; however the specific Maybo technique used during the restraint was not identified within the incident report. Bruising was reported on a body map, dated 3 February 2011 and was attached to this incident report stating "injury to named person sustained" however, there was no recorded follow up by the manager.

We saw within an incident report dated 20 September 2010 that recorded an event that evening. A person on a frequent level of observations sustained a serious self harm injury but medical treatment was not sought until the next day when they required 19 stitches. There was no mention of the risk assessment being reviewed following the incident. The accident report seen was completed 10 days later and conflicting information was recorded with that on the incident report. Timely action had not been taken to prevent further incidents or seek medical treatment.

This meant that plans could not be updated or opportunities taken to minimise and manage changing and future risks.

Other evidence

The use of language and comments that had been recorded within daily care records and incident reports showed a lack of respect and understanding of the needs of individuals and indicated that staff had a controlling approach to managing people. Published research and guidance had not been considered. Guidance such as the Department of Health's key principles of Valuing people, and Valuing People Now. The Valuing People Now Team published good practice guidance 'Personalisation through Person Centered Planning', dated March 2010 and other materials to help local areas understand how person-centered planning can help deliver Putting People First. Mencap have published a guide entitled 'Communication and People with the most complex needs. This guide provides information on ways to communicate with people who have complex needs, including profound and multiple learning disabilities which states "Communication is a human right It allows people to interact with others, express their feelings and be involved in the decisions that affect their everyday lives".

Examples of the lack of understanding and respect for people who use this service include:

Within an incident report dated 3 March 2011 we saw the statement provided by a

staff member who described one person's behaviour as 'was on the floor, not moving, not being helpful'. The incident report also recorded that two further staff members, 'applied physical restraint to prevent the person's mood escalating, however, the person's mood was becoming more problematic'. A fourth staff member helped to de-escalate the situation, as did two staff nurses. These staff members used restraint, but had recorded that this 'furthermore escalated the situation'. Another staff nurse then also helped the other members of the staff team (totalling seven staff members involved in this incident). A statement provided by another member of staff recorded that the person involved in the incident had been 'uncooperative to staff direction and she had become very agitated for no reason/trigger'. The statement from a staff member provided a differing version of the incident recorded.

Further examples we saw recorded between November 2010 and March 2011 included;

A report that the person had turned furniture upside down. Staff recorded that the person calmed down after staff said they were going to take the unit camera so as 'to take a photo to show their mother who was visiting the next day'.

A statement from a staff member who recorded that one person was "yelling like a toddler". A record that one person had 'presented themselves in a manageable mood throughout the span of the shift'. They had "complied with all directives from staff, fed well at all meals and attended for her AM and PM medication".

A daily record that "she fed well at all meals, attended for her medication and has posed no problems complying directives from staff".

An incident report that identified that an individual had self harmed with a broken cup, resulting in scratches to their arm. They approached staff with their injuries who said 'don't be mad'.

During our visit on 17 May 2011 we spent time on both the middle and the top floor of Winterbourne View. We spoke to three qualified members of staff and six support workers. All staff spoken to said physical restraint was a last resort in behaviour management. Nurses and support workers working on the middle floor said physical intervention was very rarely used there. All staff said "talking down" and use of incentives were always tried as a means of reducing behaviours before any consideration of the use of restraint, unless there was immediate danger to the person, other patients or the member of staff. Those considerations underpinned any decision to initiate restraint. All of the staff we spoke to were familiar with the format for written records of any use of restraint, and the reasons for the records. It was evident from incident reports, statements from staff, accident records and daily care notes that what staff said and what we had seen recorded do not always correspond and often provided a conflicting version of events.

Our judgement

The people who use the service at Winterbourne View did not receive effective, safe and appropriate care, treatment and support that meets their needs and protects their rights. This is because the quality of information recorded within care plans was poor, and was not person-centred. There is a lack understanding of the complex needs of people and the planning and delivery of care and treatment does not ensure the welfare and safety of people.

Injuries to people using the service and subsequent accidents reports were not followed up. Records evidenced a lack of prompt medical attention, including a lack of wound management and a lack of support and intervention to prevent self harming or attempts by people to take their own life. Proper steps were not taken to ensure each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe

Outcome 7: Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are major concerns with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We did not discuss this outcome with people accommodated at Winterbourne View. We carried out a short observation of people (see outcome 4).

Other evidence
Through discussion with the manager and staff on duty during our visits together with an examination of organisational training records and safeguarding referrals, we found that staff lacked the knowledge and expertise to support people

During this review we considered a range of documentation and information relating to the use of restraint - including serious untoward incident reports, mini root cause analysis summaries, staff statements, statutory notifications, incident records and daily care records. These documents and reports showed that the use of restraint was not always appropriate, proportionate, justifiable to the individual or considered as the last resort. We saw frequent recording in daily records of restraint being used without any recording of de-escalation techniques used prior to the restraint. This was further found in staff statements made in incident reports.

As part of this review we looked at the findings of the visiting Mental Health Act (MHA) Commissioner's report. This had been completed for the period between 18 June 2009 and 25 September 2010. It was whilst undertaking a review of safety and vulnerability of service users that it was observed by the MHA Commissioner that for one person their left arm was in plaster. The 'patient' told the Commissioner that during a restraint procedure on 23 July 2010 they suffered a fracture to their left wrist. It was recorded by the Commissioner that all appropriate action was taken to deal with the immediate incident but he was concerned to note that the 'patient' was not offered an opportunity to seek legal or advocacy advice from the resulting injury. Documents seen during that visit, including a "mini root cause analysis" of the incident carried out by the manager and deputy manager were made available to the Commissioner at his request, and this demonstrated a poor quality review and therefore very few robust lessons to be learnt or recommendations made.

The provider was asked to advise us how the hospital ensures independent reviews external to the unit are carried out when serious untoward incidents occur (as should have occurred in this case which resulted in serious injury to a patient from a restraint procedure). The Commissioner asked for a copy of the independent review of the incident on 23 July 2010, but this was not provided. The provider then submitted a report when requested by us again on 19 May 2011; the report we received was dated 20 May 2011.

During the visit to Winterbourne View undertaken on 17 and 18 May 2011 we reviewed the following documentation in relation to the serious untoward incident described above, which included, an incident form completed by a member of staff (not dated), three staff statements all dated 22 July 2010, an accident report form dated 23 July 2010, a female body map dated 29 July 2010, and a mini root cause analysis summary, dated 29 July 2010 carried out by the manager and deputy manager. The records reviewed by us were inconsistent and conflicting and this was not identified in the mini root cause analysis and demonstrated that few lessons were learned from the incident and that there was no attempt to properly review the events, identify the cause or take any action to improve safety.

The deputy manager's report on this incident was dated 23 July 2010. All staff statements were dated 22 July 2010, the day before the incident, the report to the Health and Safety Executive under RIDDOR (Reporting of injuries, diseases and dangerous occurrences) Regulations completed by manager stated the incident happened on 29 July 2010, six days after the actual event. The RIDDOR report recorded that the incident occurred on the corridor left of nurses station; however the mini root cause analysis does not record where the incident occurred; staff statements differ on the location, one states in the corridor by bedroom 22, another recorded in the quiet lounge, another that the incident occurred whilst the service user was being directed to the first floor smoking lounge, whilst another states that the incident occurred on the floor of the smoking lounge. The notification CQC received just stated 'was being restrained on the floor' The documents reviewed by us demonstrated the poor quality of the reviews and few lessons learnt after incidents involving the use of restraint.

We also examined documentation in relation to an incident dated 14 October 2010, where an incident form had been completed by a staff nurse. The report had a statement form attached which had been completed by a staff member. They had

recorded details of physical intervention involving two people who live at Winterbourne View. Part of the statement recorded that the person was removed from their bedroom and taken in the lift to the top floor quiet lounge, where they 'continued to fight, spit, scream, scratch, bite and hair pull, the person was placed in the *T Suprione position*. (Staff recorded this incorrect spelling of the restraint hold). The staff member recorded that the person was 'restrained there with a pillowcase over their mouth as they were spitting'. The same staff member then recorded that 'we stayed like that for 20 min's'. The incident report recorded that six additional staff members had been involved in the incident yet no statements had been included from them. One of the staff nurses made no reference to the use of the pillow case within the incident report. This is not a recognised form of restraint and there is a risk of asphyxiation.

At the visit made by us to Winterbourne View on 18 May 2011 we saw recorded within the daily care records dated 24 February 2011 that a person was 'restrained under a duvet for 15 mins'. As part of the responsive review this was fed back to the manager and regional director of the provider, and they confirmed that this was not an approved form of restraint.

As part of this review we looked to see what training the staff had undertaken in order to provide them with the knowledge and skills to protect the people in their care. From the information given to us by the provider we saw that 30 staff in total had undertaken safeguarding training. Of these 16 members of staff had undertaken their safeguarding training in April 2011. However, from training records we identified 23 staff who had not undertaken safeguarding at all. A nurse we spoke to during our visit on 17 May 2011 said they did not think that all staff had a good understanding of safeguarding.

We also found evidence of disciplinary action being commenced but stopped if staff resigned, with no reporting to the Independent Safeguarding Authority or Nursing and Midwifery Council (or other appropriate body) (see outcome 16).

During our visits that were undertaken on 17 and 18 May 2011 we found evidence of abuse of people who live at Winterbourne View and restraint practices were common. Our examination of records, together with a review of policies and processes, indicated that there was a systemic failure to protect people or to investigate potentially abusive practice.

All of the evidence we considered during the responsive review demonstrated that the people who use the service at Winterbourne View were not protected by effective systems to protect them from abuse. Nor did we find evidence to show that the risks of re-occurrence had been minimised.

Our judgement

The registered person had not made suitable arrangements that were effective to identify and prevent abuse from happening. They had not responded appropriately to allegations of abuse that abuse had occurred or was at risk of occurring to ensure people were protected. Therefore the people, accommodated at Winterbourne View, were not fully protected from abuse, or the risk of abuse.

Outcome 9: Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us

One person approached us and when we asked them about their medicines commented that they were happy with how their medicines were given to them.

Staff told us that they have an arrangement with a local general practitioner (GP) to provide general healthcare for people living in the hospital. People also receive medical care from the psychiatrist who works at the hospital. Everyone’s medicines are prescribed by the GP and the prescriptions dispensed for individuals by a local pharmacy. Nurses told us that people are taken to see the GP when needed and usually see the doctor who is familiar with their care. A nurse told us that they felt supported by the doctors and that the pharmacist was “only a phone call away”.

All the medicines used in the home are looked after and given by qualified nurses. Nurses told us that people come to the room where medicines are kept to be given their medicines. A list on the wall showed the various times that people were given medicines.

The hospital psychiatrist handwrites medicines administration record sheets for nurses to complete when they give the medicines. The majority of the records we

looked at showed that medicines had been given as prescribed. We did see a small number of gaps in the administration records for three people. There was no indication of whether the person concerned had been given these medicines. We also saw that one medicine had been out of stock for two days and another had been unavailable for a period of seven days and then another two day period. The nurse explained that the latter was because the dose of medicine had been increased by the psychiatrist but the prescription from the GP surgery had not been increased.

On three people's medicines administration record charts the dose instructions for some of the medicines given by nurses were not the same as the dosage instructions on the medicine labels. Nurses told us that this was because the dose had been changed by the psychiatrist but had not been updated by the GP surgery. The psychiatrist told us that he always sent an email to inform the surgery of any changes. It appeared that discrepancies were not followed up by staff. This could increase the risk of mistakes being made. Staff told us that they had arranged for this to be addressed immediately after our visit.

We saw that the appropriate paperwork was in place to document the medicines which can be given to people for their mental health when they are admitted to the hospital under a section of the Mental Health Act 1983. However two people had been prescribed an additional medicine which was not listed on the form.

A system is in place to allow medicines to be audited to check that they have been given appropriately. We looked at several of the stock check records but found that they had not been completed fully. This meant it was not possible to check that medicines had been given as recorded. There was no record that staff had investigated any discrepancies.

We saw five tubes of cream and a box of emergency treatment for epilepsy prescribed for different people that were out of date and needed to be disposed of.

Other evidence

We talked to three nurses involved with giving medicines, the deputy manager and the psychiatrist who works in the hospital. We also spoke to the local general practitioner and the pharmacist who provides services for people in the hospital. We looked at five people's care plans and medicine records used in the home and arrangements for storing medicines.

We saw a general Castlebeck medicines policy and another smaller policy specific to Winterbourne View. These showed the arrangements which should be in place to ensure that medicines are looked after and given safely in the home.

The medicine policy states that nursing staff should have an annual competency check to make sure they are able to give medicines safely. The deputy manager told us that staff had attended medicine training in April and May this year but had not had formal competency checks.

We looked at two care plans that provide guidance for staff about how medicines prescribed "when required" should be used. The medicines administration record sheet showed the maximum dose that could be given in 24 hours but the care plans did not give clear information about how quickly medicine may take effect or how long should be left before a second dose could be given. This means that people cannot be confident that they will be given their medicines in a consistent and appropriate way.

We saw that people who may need emergency treatment for epilepsy had treatment plans in place. We saw that the plan for one person who had moved from a different place had not had a new plan written yet, although one of the medicines prescribed had changed significantly.

Suitable storage was available for medicines on both floors. On the middle floor the room was 30 degrees Centigrade at the time of our visit. Records for the past month showed that the temperature was always 27 or 28 degrees C. Nursing staff commented that it was always very warm and switched on a small fan. These temperatures are above the recommended maximum of 25 degrees centigrade for the safe storage of medicines. The room used on the upper floor also felt warm but there was no thermometer and the daily temperature had not been recorded.

The service is a designated body for controlled drugs as defined in The Controlled Drugs (Supervision of Management and Use) Regulations 2006 and requires the appointment of an Accountable Officer for organisational responsibility of controlled drugs. The Accountable Officer registered with the Commission was the former registered manager. The current manager should have made application and had not done so. This means there was no Accountable Officer registered for Winterbourne View as required. There was a lack of clarity as to how these responsibilities were being fulfilled resulting in controlled drugs not always being handled safely.

Oxygen cylinders are kept on each floor for emergency use. We did not see the legally required safety warning signs for areas where oxygen is kept.

Our judgement

The registered provider did not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

Outcome 12: Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are major concerns with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us

Other evidence

As part of this review we looked at the recruitment and selection records for 13 members of staff. We also looked at other staff records including disciplinary records, conduct concerns and supervision records. In total we looked at the records for 23 staff members.

The recruitment records showed receipt of enhanced Criminal Records Bureau checks (CRB) before commencing employment for 11 people. This was not the case for all staff. For one person we saw that they had been employed from 24 January 2011; however, their CRB was dated 1 April 2011, which means that they had been in post for over 10 weeks before this had been received. We also saw that for this same person their second reference was not received until 13 April 2011. This should have been in place before they commenced employment. For a second person we saw that they were employed from 23 June 2008 although their CRB was dated 10 October 2008. There was no second reference for this person. None of these files contained evidence of either POVA first or ISA first checks.

In the case of a third staff member, their CRB showed a previous conviction. There

was no indication on file of risk assessment judging safety to employ or need for any supervision, or discussion about what the original offence was. There was no indication on files of how decisions were made to employ before the receipt of CRBs.

We saw that staff supplied two references of which one could be a personal reference. Many employer references were simple statements of dates employed with no reference to conduct, suitability or capability. For one person there was reliance on two telephone references from friends of the applicant (2006), which did not provide the employer with objective and reliable information.

It should be further noted that through discussions with staff we became aware that at least five staff had no previous experience of working in this environment and no experience of working within any care setting. This coupled with the lack of training, impacts on the safe delivery of the service, putting those who use the service at risk of unsafe staff practice when dealing with difficult situations and in supporting people with complex needs.

Our judgement

The registered provider did not operate effective recruitment procedures. They did not take appropriate steps in relation to staff who were not fit to work for the purpose of the regulated activity, for example by failing to inform the appropriate regulatory or professional body

Outcome 14: Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are major concerns with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us

During our visit on 17 May to the middle floor of the hospital, one person showed us their room and took pride in showing us photographs of their family. They named one member of staff and told us that they had a good relationship with this person, they told us; “He is alright, I get on with him ok”. Other people at this time were involved with an activities session and other people were being supported in the main lounge area and did not appear to wish to engage in conversation with us.

Other evidence

During our visits of the 17 and 18 May 2011 we asked the manager about training that staff had received. He told us of the forthcoming training schedule of training for staff and stated that training for staff had not been available “due to the organisation’s training department being in the north of the country and trainers were not prepared to travel to the south west”.

During the visit of 17 May 2011 we asked the manager for a copy of an up to date training record of all training that had been completed for all staff. We were provided with a training matrix that had been forwarded to Winterbourne View from the provider head office. We reviewed the training that had been undertaken since 18

May 2010. This was because of an 'an incident of concern', that we had seen recorded in the hospital's records, that had occurred at Winterbourne View. This was in order to see if the recorded recommendations for learning lessons had been implemented. These had been recorded as: 'staff to receive specific training on diversion/diffusion techniques and how to implement' and also that staff were to receive CAT (Coping and Tolerance) training. A review of this training matrix confirmed to us the following: of 53 staff (care and registered nurses) none of the staff had completed an 'Introduction into the SHARED Approach and CAT', the matrix showed no evidence that staff had received specific training on diversion/diffusion techniques and how to implement these or topics specific to working with people with learning difficulties.

A further review of the training matrix, confirmed through our discussion with staff and the manager that staff had not received training in any of the following areas:

Mental Health Act 1983

Deprivation of liberty safeguards

Safeguarding/Understanding of people who self harm

Safeguarding/Understanding of people who attempt to commit suicide

Autistic spectrum disorder Awareness

Challenging Behaviour

Dual Diagnosis (mental health and learning disability)

Person centred planning

The statement of purpose for Castlebeck Care (Teesdale) Ltd, available at the visit, recorded that: 'The aims of the organisation will be achieved through providing the following regulated activities: accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic and screening procedure and also the assessment or medical treatment for persons detained under the 1983 Act'. The statement of purpose recorded that staff are 'specially trained in the use of legislation and on the protecting the rights and principles of those people detained'. The statement of purpose also records that support workers are trained to learning disability qualification standard (2Q) as a minimum.

A review of the training matrix provided by Castlebeck Care records that:

Only five of 53 staff had completed supervision training (12 May 2010)

Only eight of 53 staff had completed moving and handling training (four in December 2010, four in July 2010).

Only three of 53 staff had completed communication training (one person in April 2011, the other two people in April 2010).

Only nine of 53 staff had completed emergency first aid training (3 staff in May 2010, six staff in July 2010).

Of 36 support workers, four had completed a National Vocational Qualification at level 3. 12 support workers had completed an introduction into a learning disability qualification (not an accredited qualification), leaving 20 support workers having

received no specialist learning disabilities training.

Through our examination of records and discussion with staff we saw that Maybo technique training starts with a three day course as part of induction, followed by two-yearly refreshers. The training records we saw showed that this was flagged and delivered on time. Staff said that the Maybo technique is based on "set ways of holding", so it is consistent and staff and service users recognise what is happening. All staff said the training included a lot about de-escalation and diversion. A recently recruited support worker said the Maybo technique training was the most useful training they had received, although there appeared to be a negative attitude by some staff and an absence of any formal mentoring arrangements for new employees. Staff told us: "You get those service users that enjoy it" (physical restraint), "some use it for attention", and "You can't get through to them that they are their own worst enemy".

In the minutes of a staff meeting held on 10 May 2011 it was recorded 'Staff appear to be confused as to when they should use restraint. Some nurses are practising different approaches rather than Maybo, when possible Maybo would be the right approach for certain situations'. Another member of staff raised concerns due to their 'lack of Maybo training'.

Staff told us there was a policy on self harm and it was referred to in individual risk assessments seen by us. Two nurses said suicide risk was seen as an extension of self harm. They told us that they would see value in specific training in this area. It is not currently part of the training provided. A senior support worker said: "We get a lot of self-harm – cutting, scratching, tying round neck – not covered by any training".

We obtained the following document from Winterbourne View during the site visit undertaken on 18 May 2011. It was 'a South Gloucestershire safeguarding adults alert form'. It recorded that on 18 January 2011 at 20:00hrs, for one person who was sat in the lounge that they became agitated with another person when they walked into the lounge. The first person immediately got up from their chair and went to hit the second person, person one quickly retaliated by punching person two in the face. When person one fell to the floor, person two kicked them as they got up. Within the section of the safeguarding alert form for 'what actions have been taken to safeguard the person and preserve evidence?', 'Have emergency services been contacted?', 'have the police been informed and a storm or crime reference number issued?', the deputy manager who had completed the alert form had recorded; patient to patient assault, observation levels increased for both people and they have been kept separated, X of safeguarding team informed. The findings of the root cause analysis completed on 18 April 2011 by the deputy manager and manager recorded: 'It has been established that normal procedures may not have been followed in the lead up to this incident. It occurred during evening handover when fewer staff are deployed on the floor. The findings also report: 'It does not appear the appropriate skills and diversion techniques were implemented by the staff members present at this time, this may have prevented the incident from escalating further. With the root cause analysis recommendations for lesson learning it is recorded; 'staff to receive specific training on diversion/diffusion

techniques and how to implement', also recorded is 'staff to receive CAT training'. Our review of the training information provided to us showed that this training had not been delivered to staff.

As part of this review we looked at how staff were supported in order to provide care and treatment for people who use the service at Winterbourne View. We read the supervision policy for the organisation. The supervision policy stated that this would be undertaken six times per year. One nurse told us that they had formal 1:1 supervision about three times a year, but they did not find it particularly meaningful. The expectation was that nurses were supervised by a nurse of the next grade up. Another nurse said they had received 1:1 supervision four times in six months, because they had requested it. The deputy manager told us that she had had two supervision sessions since starting employment in June 2010.

Staff told us during our visit on 17 May 2011 that the manager was suggesting debriefing sessions after incidents; this was seen by the staff as an alternative to supervision rather than additional to it. None of the staff members we spoke to had experience of planned supervision dates or the setting of a date at one supervision meeting for the next one.

During our review we found that there were very few supervision records available for consideration. A number of folders for individual staff had been set up. These contained supervision contracts ready to be signed and printed forms to guide a reflective approach to supervision, none of which had been completed. The manager said supervision had been identified as an area of shortfall, in quantity and quality; hence this attempt at a new direction, but there was no clarity about supervision relationships and no planned schedule of supervision meetings

The absence of supervision records was said, by the manager, to be due to lack of knowledge within the service about where individual supervising staff kept their records of supervision. He was unable to locate them when requested during our visit on 17 and 18 May 2011.

We saw only two actual records of supervision sessions, one from September 2010 and one from March 2011. They contained no evidence of discussion of actual work undertaken with people who live at Winterbourne View, or of outcomes as a result of training received. They were not linked to issues or objectives identified through appraisal.

A support worker said they received 45 minutes supervision with a nurse at the end of their six months probationary period, as their only experience of a formal supervision meeting. Another support worker had had a supervision session with a senior support worker during their first three months, but had not experienced it as helpful and believed supervision should be no more than being told within working time if they were doing anything wrong

Within the file a mini root cause analysis was in place this described an incident on 18 June 2010 involving a person who was detained under section 37 MHA, at

Winterbourne View who had absconded. Within the findings of the report it stated that observation levels that were prescribed appeared to be confusing for staff, consequently communication of observations required were unclear. There was an indication that staff may have played down the observation levels for the person concerned. 'Recommendations for lesson learning', recorded that those members of staff involved with the incident were to receive supervision on the importance of maintaining good observations levels. The provider had not taken action, through supervision, to support staff and make the required improvements.

We saw that a support worker had written in their appraisal in April 2009: "I am struggling to follow senior support worker directions due to shortage of staff; no time to link with senior support worker. Many things I don't understand about when and where company policies apply". There was no further appraisal on file and no indication of any response to these observations.

Records of appraisal that were seen by us concentrated on identifying training accomplished and training due or desired. Records showed these were not completed annually. We saw in one person's appraisal record they had written: "I feel I've adopted a supervisory role naturally". "I feel my manner is professional, though at times could be viewed unorthodox in my quest to gain results".

Our judgement

People who use this service do not have their needs met by competent staff. Supportive structures for staff, such as supervision, core and specialist training are lacking, and due to this we have concern for the ongoing safety for people who reside at this location.

People who live at this service are looked after by staff that are not appropriately managed and are staff that are not clear about their lines of accountability.

Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:

- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are major concerns with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us

Other evidence

In their transitional application, dated 28 July 2010, to register with us under the Health and Social Care Act 2008, the provider declared the name of an individual to be the Registered Manager at Winterbourne View. On 10 December 2009 the provider had appointed a different person to the post of manager at Winterbourne View, and this was effective from 1 January 2010.

On 21 January 2011 we issued a certificate in the name of the person who we had been told was the manager. The certificate registered that person to carry on the regulated activities at the location Winterbourne View. At the time of our site visit in May, we were informed by the manager that the person who had been named to us by the registered provider did not in fact work at Winterbourne View and was managing another location for the provider elsewhere in the country. We had not received any notification from the provider to inform us of the new management arrangements at the hospital. An application to register from the manager in post at the time of the review had been received by us and rejected on 21 April 2011. The application was rejected as it did not contain all the required documents and an out

of date application form had been used citing the previous legislation. At the time of our site visit no further application had been received by us.

The registered provider stated that they operate a Quality Management System (QMS) as set out in their Quality Manual. The integrity of this system cannot be assured; for example, the manual refers to previous legislation, the Care Standards Act and National Minimum Standards throughout the document to support the objectives of the QMS.

The registered provider failed to effectively implement these systems to assure themselves of the effective operation of systems. The following examples have been identified:

'Staff will be 'continuously' trained and 'self development encouraged' The resource management processes identify that the *'effectiveness of training is evaluated to ensure that the required competence is achieved.'* As set out earlier in this report within outcome 14 (supporting workers) we have evidence that staff have not received appropriate training and professional development.

Within the Quality Manual the section relating to *'Development of service user plans'* sets out a clear process of review for people who use the service. As set out in this report on outcome 4 (care and welfare of people who use services) we have evidence that process has not been followed and quality audits were not in place to assure the provider that the QMS met the stated requirements.

We have found a lack of follow up and review of incidents. For example - within an incident report for a person who used the service at Winterbourne View dated 3 March 2011 we found that staff had not recorded a range of information relating to the severity of incident, follow up, or in relation to potential contributory factors. We saw that staff had not completed the brief description of events 30 minutes prior to the above incident, there was no record of the staff members involved in the de-escalation, and there was no description of the de-escalation methods used. The incident report gave no indication that the service user's risk assessments were reviewed following the incident as stated on the form.. The manager did not scrutinise the incident until 1 April 2011, almost one month after the event.

During our review we saw an incident form dated 17 January 2011, which recorded that a person was 'restrained on three occasions earlier and had appeared settled'. This same person then followed a member of the staff to the treatment room and casually mentioned absconding. They then banged through the exit door and left the building. This person was missing from the location for 30 minutes. A mini root cause analysis had not been completed until 18 April 2011, three months after the incident.

Information recorded within the unit-led clinical governance committee meetings was not robust and lacked enough detail to inform a quality review of the clinical and nursing interventions and activity at Winterbourne View. The last meeting was held on 15 February 2011. Minutes of meetings we reviewed were brief with no clear action plan or evidence of clinical lead and direction for staff.

A significant incident occurred on 11 April 2011 requiring police intervention. The incident was recorded on a serious untoward incident report completed on 19 April 2011, eight days after the event. This recorded that the staff on duty were unable to manage or restrain people at the service, so the police were called to the unit for assistance. Police intervention resulted in three of the people who live at Winterbourne View being put in handcuffs and leg restraints.

Considering the seriousness of the events, and the actions and behaviour of four people that used the service, we would have expected that this situation would have been a priority for review in order to provide an opportunity to identify assess and monitor risk. We were informed by the safeguarding lead for South Gloucestershire Council during a safeguarding meeting held on 13 May 2011 that the manager had been asked to complete a root cause analysis on this incident; this had not yet been done.

The serious untoward incident report proposed, as future preventative action, that all staff should receive CAT (Coping and Tolerance) training and de-escalation training. The training records we reviewed identified that this had not been arranged or taken place.

A further action was to introduce a twilight shift to ensure that extra staff were on duty before people retired to bed. Our review of the staff rotas identified that this had not been put in place, and this was confirmed when we visited on the evening of 24 May 2011. Six staff were on duty at the time of our arrival and we were told that there was no extra staffing on the top floor before people go to bed. Staff we spoke to were unaware of such a shift and that the shift for night duty was from 8pm to 8am.

Actions and learning points from incidents focused on the control of people who use the service rather than staff practice; for example, lack of detail and rigour in root cause analysis reports we reviewed, no record of patient views when incidents have occurred, and incomplete or brief investigations carried out by the registered person in relation to the conduct of staff. Examples of this are:

On 11 October 2010 the manager received an e-mail from a member of staff which outlined a number of serious allegations concerning the conduct of other staff. In the email it was stated that he had previously raised concerns that had not been acted on by the manager. The manager did not act on this information for some time and did not make any follow up enquiries. We checked the file for this person and found no records of any concern raised, grievances or attempts to contact him. There was no evidence to suggest that they had taken any action to keep people safe or had carried out an investigation in relation to the concerns that had been raised..

Staff files showed that in June 2010 a support worker had been suspended. The reason given was that they had '*acted inappropriately and had locked a patient between two doors*'. Although the provider had suspended this member of staff, this incident was not reported as a safeguarding concern to the local authority as required. This person resigned from the company on 21 September 2010. As this

allegation had not been investigated under safeguarding protocols no decisions had been made to ensure the safety and protection for people who use this service; furthermore, this person had not been reported to the Independent Safeguarding Authority (ISA) to enable them to consider if further action were needed. The registered provider did not inform CQC of this incident.

We saw that another member of staff was suspended in March 2011 following an allegation that they had 'head butted a patient and had used an inappropriate Maybo technique'. A disciplinary panel found that the staff member's actions were not 'reasonable or proportionate'. The same staff member had been the subject of a disciplinary meeting that was held on 28 June 2010. Notes recorded that this meeting was held due to 'inappropriate restraint causing a patient injury'. We could see no evidence of any supervision for this person and they not been reported to the Independent Safeguarding Authority. The registered provider did not inform CQC of this incident.

In records for a third member of staff, a registered nurse, we saw that a meeting had been held on 17 June 2010 to discuss with them an incident when a patient had injured themselves resulting in them requiring hospital treatment. The registered nurse, who had been in charge, did not attend to the person's wounds as needed. They had not completed required documentation, for example, the accident report dated 30 September 2010 had been completed 10 days retrospectively. This registered nurse left the organisation before the investigation had been completed and they were not reported to the Nursing Midwifery Council or the Independent Safeguarding Authority. The provider did not inform the CQC of this incident.

The evidence has shown that processes are not followed to ensure that nursing and care practices reflect best practice, or to ensure that each person's needs are met safely to provide for outcomes that comply with the Essential Standards of Quality and Safety and that meet the stated objectives of the organisation as detailed in the Quality Manual.

Our judgement

People who use the service at Winterbourne View do not receive safe, quality care, treatment and support, due to ineffective decision making and poor management of risks to their health and safety. We have evidence of a lack of leadership and management and ineffective operation of systems for the purposes of monitoring of the quality of service that people receive.

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

There are major concerns
with outcome 17: Complaints

Our findings

What people who use the service experienced and told us

In total we spoke to 10 people who live at Winterbourne View in order to establish if their comments and complaints are listened to and acted on effectively.

Three of the people we met at the service said that they would talk to a member of staff or to the manager if they had a complaint. Two other people told us that they would tell their relatives or friends if they had a complaint as this would be listened to. Within daily care records we saw that people who live at Winterbourne View had raised complaints in the past to staff but these had not been taken seriously and had been ignored.

Other evidence

The registered provider has a complaints policy in place. This was dated 21 June 2010, and is recorded as due for renewal on 21 June 2013. Within this policy it was recorded that the complaints policy is based upon the Independent Healthcare Advisory Services Code of Practice for handling patient’s complaints. The policy records that the key principles of the complaints policy are: accessibility, impartiality, simplicity, speed of redress, confidentiality and improvement in quality of resident

care. The policy's definitions of complaints include: 'Complaints may relate to the quality of care, professional competencies. Complaints may also be clinical, or non clinical and may be directed to any members of staff, clinicians or other users'. The policy's supporting objectives include: 'to have an honest and thorough approach to investigation, to address legitimate concerns raised by the resident or their authorised representative'.

During our visit to Winterbourne View on 17 May 2011 we asked the manager for a copy of any complaints that had been made; this was not given to us. We asked for this when we visited the service again on 18 May 2011 again; this was not given to us. We rang the service on 19 May 2001 and arrange to collect this information from the service on 20 May 2011. On this occasion we were informed by the provider that no records were available. We were also told that the service, including the manager, had not received any complaints since 2009

We know from daily records that complaints have been made to the manager and staff but these had not effectively been acted upon in accordance with the policy set out in the Quality Manual. For example, one person made a complaint to the manager on the 18 March 2011 and then made a further complaint in writing on 1 April 2011 to the manager. We requested the record for how this complaint was managed and on the 19 May 2011 we were informed by the registered provider that no records were available.

We saw in one person's daily care notes dated 3 March 2011 that their relative rang Winterbourne View and spoke to a staff member. The relative reported to the staff member that they had been told by their family member that; 'earlier that day two members of staff had laid across their relative's chest, whilst restraining them, causing chest pain'. We know from the records for this person that they have a history of heart problems. No action had been taken in response to the concerns, it had not been reported as a safeguarding concern, and no action was taken to investigate the allegation..

We saw the minutes of the unit-led clinical governance committee meetings for 23 September 2010 where a relative had contacted the service in respect of 'lost money', but no further information or action taken is recorded. In the minutes of a meeting held on 4 November 2010 another relative had complained that they had not been kept informed of their relatives care. Again, no further information or action taken is recorded. In the minutes of the meeting held on 13 December 2010 it is recorded that; X's family were complaining about management and also about coming to see their relative' There was no record of any action taken,

Our judgement

The registered person does not have in place an effective system for identifying, receiving and handling complaints. This has had an impact on the quality of care, leading to unsafe or inappropriate care or treatment.

Outcome 19: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983

What the outcome says

People using the service who are detained under the Mental Health Act 1983:

- Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

This is because providers who comply with the regulations will:

- Notify the Care Quality Commission about the death or unauthorised absence of a person detained under the Mental Health Act 1983 who uses services.

What we found

Our judgement

There are major concerns with outcome 19: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983

Our findings

What people who use the service experienced and told us
We did not discuss the outcome with people using the service.

Other evidence
The registered provider had not notified the Commission, as required, of the unauthorised absence of three people, for four occasions when they had absconded. One person was detained under section 37 of the Mental Health Act 1983; the other two people were detained under section 3 of the Mental Health Act 1983.

On 19 May 2011 we requested incident reports of when people had absconded, or had attempted to abscond, from Winterbourne View. A review of the information provided evidence that CQC had not been notified of the following unauthorised absences for people as required.

An incident report dated 17 January 2011 records that at 'approximately 19:10 the person left the floor and subsequently the building. The alarm was raised; 'on-call' staff were informed at 19:25; the police were informed at 19:30; the deputy manager arrived at the unit at approx 19:45 to help search for the missing person'. At 19:50 the police came to the unit to gather more information, and at 20:00 the person was found and brought back to the unit by the police. A statement form completed by the deputy manager and records that the person was found by the police on The Old Gloucester Road and was brought back to the unit by three policemen. On the statement the deputy manager recorded that the service user had stated to staff member, "I was only just down the road, hidden in the bushes down there, I was watching you all search for me".

The mini root cause analysis for this serious untoward incident was completed by the manager and the deputy manager on 18 April 2011, three months after the incident. The Health and Social Care Act regulations state that the registered person must notify The Commission 'without delay'. This incident was not reported to the Care Quality Commission.

In another incident report dated 28 November 2010, a statement from a staff nurse, records that they were 'informed by a patient that another patient had "done a runner". Several staff went after the missing person and it was later reported that they had "run into the NHS car park and was then escorted back to the unit'. Another staff member recorded 'we found X around the NHS entrance and attempted to talk X into walking back, we used rapid escort technique with me supporting X's back.' There were no timings recorded for the time of return to Winterbourne View. A statement from another staff member records that X 'attempted to abscond at 09:30 am, breaking through two sets of doors. X made it around 30 yards from the unit before being 'carried' back'. There was no record of return time to Winterbourne View.

A further Incident report dated 29 September 2010 related to two people who live at Winterbourne View Y & Z. We examined a statement form from a staff member, which records that at 20:10 they were informed by another staff member that they were searching for Y and Z. At the same time a member of staff took a phone call from another staff member who informed that they had seen both Y and Z at the unit car park absconding. Two staff left the building with another staff member. They spotted an image of Y hiding in the neighbourhood NHS car park and ran towards them, on getting there also spotted Z'.

A member of staff reported in their statement form that they 'ordered' them both to start returning to the unit. No times were recorded in any of the staff statements or in the incident report completed by another staff member of when both individuals returned to Winterbourne View.

The file of information given to us by the provider on 20 May 2011 also contained two serious untoward incident reports. One related to person Y and records: "Patient detained under section 3 of the Mental Health Act absconded from the hospital grounds on Sunday 24 October 2010". Actions recorded included an immediate search of unit and grounds, unit vehicle taken to search the area. The report also recorded that person Y was 'quickly found safe a mile away from the unit and was

escorted back by staff'. There was no evidence of a mini root cause analysis being completed, no incident report available, no risk assessment was available, and no lessons learned documented.

A serious untoward incident dated 16 February 2011, related to person A and person B. The report recorded that 'two detained service users absconded during a community trip'. It was recorded that CQC were to be notified and a mini root cause analysis was to be completed. We did not receive a notification of this incident and a mini root cause analysis was not provided to us as part of the information requested detailing this incident.

Also within the file given to us by the registered provider was a mini root cause analysis describing an incident on 18 June 2010 involving person A. The mini root cause analysis records "patient under section 37 MHA, at Winterbourne View absconded. The police, the manager, and NOK were informed, and staff searched immediate area. Police found person A and they were back in the unit within an hour of absconding". We were not notified of this incident.

Our judgement

The registered person does not ensure that important events that affect the welfare, health and safety of people who use this service are reported to the Care Quality Commission in order that we can be confident that action, where needed, had been taken to keep people safe.

Outcome 20: Notification of other incidents

What the outcome says

This is what people who use services should expect.
People who use services can be confident that:

- Important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are major concerns with outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us

We did not discuss this outcome with people using the service.

Other evidence

During our visit on 24 May 2011 we asked a registered nurse about the procedure for reporting any incidents to CQC via a notification. The registered nurse was unsure which incidents would be reported to CQC and told us that as nurse in charge they would be responsible for completing the internal documentation such as the incident form, which is then passed to the manager who they thought would then decide if a notification was required.

In the daily care notes for a person who lives at Winterbourne View we saw recorded on 2 March 2011: 'When X had received a phone call from their mum, their mum asked to speak with a support worker and X's mum told me that X had told her that two members of staff were lying across her chest whilst restraining them during that day and it had caused them chest pains.' This allegation was not reported to the Care Quality Commission nor to South Gloucestershire Council safeguarding team, and there were no records of any management reporting. There is no record of how this incident was dealt with by the provider.

In the daily care notes for person X a staff member recorded that on 5 March 2011 X 'informed staff that their mum hit them during their visit, according to X it was due to them phoning the police. X reported that they hit their mum back'. Also within the daily care record for the same date it is reported that: 'X said that their mum punches the back of their arms and legs'. This allegation was not reported to CQC, or to South Gloucestershire Council safeguarding team, and there were no records of any management reporting. There is no record of how this incident was dealt with by the registered provider.

An accident report seen by us for person Y, dated 4 April 2011 records that Y was attacked by person Z and was injured when they put their hands up to protect themselves. Injuries sustained included a swollen and bruised finger. This was not reported to us.

During our site visit on 18 May 2011 we asked the deputy manager to provide us with an update of all safeguarding referrals made by Castlebeck Care (Teesdale) Ltd, from 1 May 2010 up to and including the 18 May 2011. A handwritten list was provided by the deputy manager; however this does not record/include any of the above incidents.

When we reviewed the minutes of the unit led clinical governance committee agenda meetings for 23 September 2010 we saw that a relative had contacted the service in respect of 'lost money', but no further information or action taken is recorded.

As part of this review we requested further information about safeguarding alerts from South Gloucestershire's safeguarding team. This demonstrated that none of the above allegations had been reported to South Gloucestershire's safeguarding team, which would have enabled further investigations to have been made to ensure that people were being safeguarded.

Our judgement

The registered person does not ensure that important events that affect the welfare, health and safety of people who use this service are reported to the Care Quality Commission in order that we can be confident that action, where needed, had been taken to keep people safe.

Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and wellbeing are maintained and held securely where required

What we found

Our judgement

There are major concerns with outcome 21: Records

Our findings

What people who use the service experienced and told us

We did not discuss this outcome with people using the service. However the evidence we found showed that records kept were not accurate and these failings impacted on the care people received.

Other Evidence

We reviewed documentation and information relating to the use of restraint - including serious untoward incident reports, mini root cause analysis summaries, staff statements, statutory notifications, incident records and daily care records. These documents and reports do not provide evidence that the use of restraint was always appropriate, proportionate and justifiable to the individual.

Within the registered provider's Quality Manual the section relating to 'development of service user plans' sets out a clear process of review for people who use the service. As set out within outcome 4 (care and welfare of people who use services) within this review we have found that process has not been followed and quality audits were not in place to assure the provider that the Quality Management System met the stated requirements

When we reviewed the administration and recording of medication we found the records were not accurate. We looked at two care plans that provide guidance for staff about how medicines prescribed PRN, "when required" should be used. The medicines administration record sheet showed the maximum dose that could be given in 24 hours but the care plans did not give clear information about how quickly medicine may take effect or how long should be left before a second dose could be given. This means that people cannot be confident that they will be given their medicines in a consistent and appropriate way. We found several stock check records that had not been completed fully. This meant it was not possible to check that medicines had been given as recorded. There was no record that staff had investigated any discrepancies.

During our visit on 25 May we sat in on the shift handover from the day to night staff. The nurse in charge of each floor gave a handover using the handover books of which there is one for each floor. The handover books have record sheets for each 24-hour period for staff to document the following: the names of staff on each shift and which floor they will work on, a summary overview of each patient in the 24 hour period, filled in by each shift, a section where the observation level for each patient is detailed from level 1 – 4, a section for daily checks where staff names are added against each task and also an activities planner. We saw that the book for the upper floor for May 2011 did not have completed activity planners on any days and that the daily check lists and observation levels for patients were not completed on ten days since May 1st 2011.

When we visited Winterbourne View on May 24 we asked to look at a further four people's care planning approach care files. These were for the people who had been involved in a serious untoward incident on 11 April 2011, involving the police. We wanted to see if their 'as and when required', (PRN) medication and physical intervention care plans had been reviewed and updated. We were given photocopies of one persons identified risks care plan dated 28/4/11. This had been completed seventeen days after the serious incident. It set out how they were to be supported if there was 'non compliance with medication and a limited response with PRN medication'. We were told by a senior registered nurse on duty that their physical intervention care plan had not been completed and was not in either their care planning approach file or their 'fast track' care file. (We were told 'fast track' files contained the most up to date information about patients including risk assessments). We were given a copy of their most recent physical intervention risk assessment dated 19/01/11; this had not been updated since the incident.

We reviewed the documentation for the people we have previously reported who had, or had attempted to abscond from Winterbourne View. We did not see any updated or reviewed risk assessments relating to action that should be taken if these people abscond from the hospital. There was very little evidence to show what lessons had been learnt in order to prevent this situation from recurring and placing people at risk of harm.

Our review of accidents showed us that from 1 January 2011 to 27 March 2011 one person had either injured or self harmed herself on ten occasions. The incident form contained no comments from the next of kin to show that they had been made aware of the accident and the injuries sustained, there was no record of the description of the incident being given to the person involved and no review of the risk assessment.

Our judgement

The registered person does not ensure that the people who use this service are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

Accurate records are not maintained in respect of the care and treatment provided. Other records in relation to staff employed and the management of the regulated activities carried out at Winterbourne View are also not appropriately maintained.

Action we have taken

CQC has taken enforcement action to remove the location, Winterbourne View, from the provider's registration.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA