### Partnerships in Care Limited
#### Kemple View

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<th>Region:</th>
<th>North West</th>
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| Location address: | Longsight Road  
Langho  
Blackburn  
Lancashire  
BB6 8AD |
| Type of service: | Hospital services for people with mental health needs, learning disabilities and problems with substance misuse |
| Date of Publication: | September 2011 |
| Overview of the service: | Kemple View currently provides a low secure environment for men suffering from a mental illness and or a personality disorder. It is set in the Ribble Valley area of Lancashire with surrounding countryside. There are public transport links into surrounding areas and the city of Preston. There are |
| recreational facilities on site that include occupational therapy horticultural area, a gym, education room, art and woodwork workshop and therapy rooms. The hospital has a shop on site also. |
Our current overall judgement

Kemple View was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 2 August 2011, carried out a visit on 5 August 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People we spoke to were generally happy with their care and treatment at Kemple View. Some people said they wanted more going on at the weekends and still had concerns about their planned leave being cancelled. People told us that they were informed of their rights under the Mental Health Act on a monthly basis. Most people we spoke to said they felt safe but this was not reflective of all the people we talked to. People told us they were able to self administer their medication and support was provided for them by the hospital.

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

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who use the service are involved in making decisions about their care treatment and support and are able to express their views so far as they are able to do so.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Suitable arrangements and completed records were not in place to provide continuing support for people who used the service who may have lacked capacity to consent in relation to the care and treatment provided for them.
Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People who use the service experienced effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People who use the service have not always received care, treatment and support from staff that had not completed the appropriate training in relation to de escalation, and the management of behaviour.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The service does not fully protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for their obtaining, recording, handling, using and safe administration.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People who use the service were not always protected against safe and suitable premises. The premises were not being adequately maintained and the appropriate measures were not in place to address environmental risks identified.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People using the service are safe and their health and welfare needs are being met by sufficient staff to support people. There are processes in place to review staffing levels and patient need as a basis for deciding sufficient staffing levels. Systems are in place to review and respond to unexpected circumstances within the service.

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 using the service benefited from safe quality care and support, due to effective decision making and good management of risk to their health, welfare and safety.

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

There were effective systems in place to deal with complaints and patient complaints are acknowledged and investigated.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this
report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

Please see previous reports for more information about previous reviews.
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 01:
Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
When we visited the wards we spoke to patients during our visit, some patients told us they felt they were respected by the staff but one patient told us that he felt others on the ward were not respected by the staff.

Most of the patients we spoke to told us they were aware of the advocacy services available.

Other evidence
The service sent us a copy of their Provider Compliance Assessment (PCA) as part of this planned review. The PCA submitted for this outcome identified that they were compliant for this outcome.

We visited Arkwright ward and observed care being provided. Patients were unoccupied and wandering around the ward area without meaningful staff interaction or stimulation. One person we observed experienced difficulties communicating and had been given lunch in the lounge area by a staff member who referred to the patient by his name only. The interaction between the staff member and the patient was observed to be minimal and invalidating. A staff member told us that the period we observed was low stimulus for the patient and the reason for the limited interaction.
We observed some good communication with patients and we saw that when patients were spoken to in an enabling, warm and fun way the patients responded positively. We observed patients eating alone in the dining area and minimal staff interaction was observed during the meal.

Advocates were available within the hospital and information was displayed on all the wards we visited.

We saw patients were being supported and enabled to access community services. Staff told us that they tried to make visits away from the hospital as equitable as possible so that all patients who may not have been as vocal as others, received the opportunity to access leave in and out of the hospital grounds. Weekly meetings had taken place on the ward we visited and these had been documented, this showed that patients had being consulted to plan any visits.

We looked at minutes from the patients' council meetings that had taken place every three months. Patients told us they were representatives on this group. All but one ward had provided representations on behalf of other patients to voice their views of the hospital. Weekly meetings were taking place on the wards we visited to consult and plan visits out.

As a result of the patient surveys that had taken place requesting more information about their care and treatment in the hospital, this had been provided to patients.

Staff told us that patients had been consulted about the food they received at the hospital and a survey had been completed with the patients around the food options available. The chef visited the wards on a regular basis to discuss issues around the food being served.

**Our judgement**

People who use the service are involved in making decisions about their care treatment and support and are able to express their views so far as they are able to do so.
Outcome 02: Consent to care and treatment

What the outcome says
This is what people who use services should expect.

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

Our judgement
There are minor concerns with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
People told us that they were informed of their rights.

Other evidence
The service sent us a copy of their Provider Compliance Assessment (PCA) as part of this planned review. The PCA submitted for this outcome identified that they were compliant for this outcome.
The PCA told us that local audits were undertaken to assess the use of consent to treatment that included a quality and accuracy of consent related record keeping. This covered, document management, completion of patients consent to treatment, forms that included entries made by clinicians and responsible clinicians in clinical notes to establish consent to treatment, or obtaining a second opinion doctor as well as well as the quality of completion of patients medication cards.

We visited Arkwright ward and looked at patient records in relation to the capacity of an individual. We asked to see records made in relation to the individual. We were told by staff that the individuals' capacity to consent had been addressed; however there were no written notes or no Independent Medical Capacity Advocates (IMCA) involved. There was no information or written records of assessment of capacity available with regard towards the Mental Capacity Act 2005.
We looked at the policy in place, consent for examination or treatment. This included all the necessary forms to be completed where an individual is unable to consent to investigation or treatment.

We looked at forms authorising people’s treatment. These were kept with the prescription charts. We saw examples were these forms and consent had been reviewed annually, but also examples where review was less frequent. We could not always find records of consent interviews within people’s clinical notes. (Please see Outcome 9)

**Our judgement**

Suitable arrangements and completed records were not in place to provide continuing support for people who used the service who may have lacked capacity to consent in relation to the care and treatment provided for them.
Outcome 04:
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
The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
One patient told us they had been involved in writing their own care plan and had taken full ownership of his care plan. We were told that he knew what was written in the care plan it and this is encouraged by the staff. "I aim to be independent".

"Staff are on corridor at night as part of their night duty but make noise by laughing and I find it hard to sleep at night"

One patient told us that he had refused to complete his needs assessment because he didn't like his key nurse. The staff completed this on his behalf. He told us, "How do they know what my needs are?"

"We are informed of our rights monthly"

When we visited some patients they said they were satisfied with the range of activities available to them. However others said that there are not enough activities available at weekends.

Other evidence
The service sent us a copy of their Provider Compliance Assessment (PCA) as part of this planned review. The PCA submitted for this outcome identified that they were compliant for this outcome. This told us that a physical health care pathway, was in place at the hospital. This ensures the early identification of ill health, access to physical health care and ensures healthy choices and options are provided. The
pathway covers the patient’s journey from admission to discharge. Where a patient has a diagnosis of learning disability they are supported with a health action plan that is developed by their Primary Care Trust (PCT).

They told us that every patient was assessed using an assessment for the prediction and management of the risk of violence. Where other risks are identified specific tools are utilised, including the SVR-20 for risk of sexual violence, Short Term Assessment of Risks and Treatability (START), Structured Assessment of Violence Risk in Youth (SAVRY) for younger patients, and the Beck Depression Inventory for depression. Risk assessments were also completed for individuals who may have a substance misuse related issue.

It told us that seclusion is used in the hospital in exceptional circumstances and policies and procedures are are in place and the Therapeutic Management of Violence and Aggression (TMVA) techniques are used, supported by their policy. This was carried out following clear procedures that are monitored, reviewed and in line with the Mental Health Act 1983 (amended 2007) and the Code of Practice.

We looked at patient files and care plans these included personal details, referral details and assessments, admission details, nursing documents, clinical notes, ward record notes, Care Programme Approach (CPA) documents, risk assessments, leave documents, physical health information, incident reports, Occupational Therapy (OT) reports, psychology reports, social work reports and 3rd party information, miscellaneous and other correspondence, including a property list.

One file we looked at did not recorded discussions held with a patient during their ward round to address their reduced level of leave from the ward; this was discussed with the hospital management team.

We looked at clinical patient record files and these were not always signed by the nurses and some records were not dated. We looked at a patient off ward risk management plan that had no signatures and an incident report (IR1) that had been completed but was unsigned and not dated.

The hospital was in the process of updating individual patient care plans to implement a standardised needs assessment tool called a Recovery Star (Mental Health Providers forum 2008). This tool was being used to assess and measures change to support the individual patients’ recovery.

The care plans looked at addressed the individual needs, goals and steps for patients to aim for along the way. A risk management plan for off ward activities and longer term risk management plan was also in place.

We were told that ward rounds are held weekly for some patients and other patients receive two weekly or monthly ward rounds with their psychiatrist and their Multi Disciplinary Team (MDT) involved in their care. Staff told us that should a patient become unwell or request to see their MDT before their next appointment then this would be arranged.

Staff and patients told us that they had weekly patient community meetings on the wards where patients and staff planned ahead for patients leave and visits inside and outside the hospital.

We spoke to staff who said they needed more staff to facilitate planned visits and
outings. Other staff members told us the increase in escorting staff over the past few months had been working well as the level of observations had decreased which meant a reduction in the number of visits and trips being cancelled.

**Our judgement**
People who use the service experienced effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
Outcome 07:
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

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| **What people who use the service experienced and told us**
People told us "I'm as safe as I could be here, I look after myself and I feel safe here".

One patient told us he felt frightened on one ward and this was discussed with the ward manager and the management team who confirmed this would be discussed with the patient to seek further information from the patient regarding his concerns.

**Other evidence**
We observed care on all the wards and a staff member had been allocated to undertake observation of patients' whilst they were in their bedrooms. Staff and patients told us this had recently been implemented to protect patients' when they went to their rooms during the day. This was a result of a review of the safeguarding policies and procedures and notifications submitted to the CQC to prevent any abuse from happening within the service.

We were told that incidents and, adverse events, errors and near misses are reported and recorded on a corporate database by staff on the wards. These incidents were reviewed by the organisation.

The hospital had a whistle-blowing policy in place.

Notifications had been submitted to the CQC and these had included notifications to the relevant safeguarding teams and commissioners who fund individual patients. Staff told us that if any safeguarding issues had been identified between patients on the
wards then a safeguarding meeting would be initiated and if necessary patients would be moved to another ward.

We looked at training records. These indicated that out of approximately 127 staff members, four staff required updated training in relation to safeguarding. We looked at training records in relation to de escalation, breakaway training and the management of violence and aggression also. These records indicated that de escalation update training was required for approximately a quarter of the staff and the management of violence and aggression was required for 8 staff members.

Our judgement
People who use the service have not always received care, treatment and support from staff that had not completed the appropriate training in relation to de escalation, and the management of behaviour.
Outcome 09:
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 minor concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We spoke with nine people about their medicines and the care they received. People we spoke with had some awareness of the medicines they were taking although due to a variety of complex needs, some people were less able to discuss their medication with us. One person we spoke with said they knew exactly what they were taking and that they were happy with the arrangements in place to support them to self-administer their medication. We were told that the doctor or nurses discussed their medicines with them. Another person had their medicines administered by nurses. They told us that the nurses normally had all the medicines they needed, and 'if they run out it's only for a day or two'. Managers we spoke with were aware of this and told us about the action they were taking to try and ensure adequate stocks were maintained. We asked how people could receive treatment for minor ailments. One person told us 'if you get a headache you just ask for some paracetamol'. Nurses confirmed that the service kept a stock of discretionary medicines for this purpose.

Other evidence
We found that people's medical needs were provided for by specialist doctors and a GP who visited the hospital once a week, as well as by suitably qualified nurses. Managers told us that they had recently introduced an annual medicines competency assessment to help ensure that medicines were handled safely. We saw that one person administered some of their own medicines. But, no risk assessment or care plan was in place to support this. Managers explained that new procedures were being introduced to help ensure that self-administration was better assessed. We saw that two patients
were currently working through a medicines booklet as part of the new process. Medicines for peoples physical health needs were administered from supplies prescribed and labelled for them. We found examples where the instructions on the pharmacy label differed from those on the hospital prescription chart. We saw that nurses followed the instructions on the prescription chart but had not confirmed which of these instructions was correct.

We looked at medicines stock control. We found it difficult to account for people's medicines because there was no clear system in place for recording quantities of medicines brought onto the ward. Additionally, there was no standard code for recording when medicines doses were missed. This means when recording errors were made, such as not signing the medicines charts, nursing staff could not assess whether medicines had been given correctly. Managers explained that they were testing a new ordering system where the supplying pharmacy would check stock levels and order all the medicines needed for that ward. And, a new stock record book was being rolled out to help account for medicines received into the hospital and improve stock control.

We looked at a sample of people's care plans. We saw that medication was discussed as part of people's care planning and that the possible side effects of medicines were properly monitored. Forms authorising people's treatment were kept with the prescription charts. We saw examples were these forms and consent had been reviewed annually, but also examples where review was less frequent. We could not always find records of consent interviews within people's clinical notes.

We found that medicines were safely stored and that medicines for medical emergencies were available and checked by nursing staff.

**Our judgement**
The service does not fully protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for their obtaining, recording, handling, using and safe administration.
Outcome 10: Safety and suitability of premises

What the outcome says
This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement
There are minor concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
Patients told us that they have to have two members of staff to accompany them into the outside enclosed garden area, but when they are on ground leave they do not have any staff member with them and they could not understand why?

Patients told us that they have access to the outside enclosed garden area.

Other evidence
We visited Elmhurst ward accompanied by the fire safety enforcement officer due to concerns that had been raised by the Mental Health Act commissioners in relation to a fire door. We looked at the overall fire risk assessment for the hospital and a fire risk assessment action plan. The fire risk assessment action plan had been completed and the fire safety enforcement officer had met with the hospital health and safety adviser to address issues highlighted.
The fire safety enforcement officer told us that all fire doors should be checked and maintained on a regular basis, this had been discussed with the health and safety adviser at the hospital.

We looked at the fire door escape route on one of the wards where concerns had been raised and the fire safety enforcement officer told us that he was satisfied with the current fire door in place.

We visited Wainwright ward and looked at the environment and bathrooms available for patients on the ward.
There were no disabled facilities available on the ward. Should individuals need to
access disabled facilities in the upstairs bathroom they would not be able to, unless they could use the stairs. There was no hoist available to assist individuals who may need to access the bathroom should they have any physical disability. We were told by the management team that should the need to accommodate someone who may need any specific aids and adaptations to assist them; this would be addressed within the pre assessment and a hoist is available on Arkwright ward that can be moved around the site as necessary. We were also told that should some one who required specific aids and adaptations to assist them with their disability, this would be addressed and the necessary arrangements made that might include moving the patient to a more suitable ward.

There where two showers available downstairs on the ward, one was a walk-in shower that had a damp problem. Tiles were loose and the sealant required replacing. The other downstairs shower we looked at needed the water hose to the shower replacing. We asked to look at the ligature risk assessment as concerns were raised with the design of the shower in use and the condition of the hose. We were unable to view the ligature risk assessment. This was raised with the ward manager and management team who informed us that the issues we highlighted would be addressed immediately. The ward was clean and tidy however some of the carpets in the bedrooms needed to be replaced due to wear and tear.

We saw that a staff member had been allocated to undertake observation of the upstairs bedrooms whilst patients had access to their rooms. We were told that this was in place to make sure that the patients are safeguarded from the risk of other patients entering their rooms.

Patients had access to outside enclosed areas where two staff members accompanied patients; we were told that this was to ensure that patients were safe. We were told that the ward will be refurbished and work will commence by the end of the year 2011.

**Our judgement**
People who use the service were not always protected against safe and suitable premises. The premises were not being adequately maintained and the appropriate measures were not in place to address environmental risks identified.
Outcome 13:
Staffing

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 sufficient numbers of appropriate staff.

What we found

Our judgement
The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Patients told us that their leave is still being cancelled but it has got better. One person told us that leave is taken off patients if they have been alleged to have done something wrong even if the staff were unable to prove it.

We were told by staff that staffing levels had improved and extra staff always helps but some staff told us that sometimes there was too many staff on the wards.

A patient told us that he felt respected by staff but sometimes other patients were not respected.

Staff told us that more staff were required to facilitate ground leave for patients and staffing can be a problem where male only staff were required to accompany patients.

Patients told us that they have to have two members of staff to accompany them into the outside enclosed garden area, but when they are on ground leave they do not have any staff member with them and they could not understand why?

Other evidence
The PCA submitted for this outcome identified that they were compliant for this outcome.

It told us that the staffing skill mix was reviewed at ward managers meetings and twice weekly at a resource meeting. Staffing levels were also reviewed within the clinical
governance meetings and with the senior executive team. They reported that changes had been made to staffing levels and grading in relation to Psychology in response to requests from the commissioners of the service.

Concerns had been identified before our visit that there had been insufficient staff to support patients when taking planned leave. We were told by the hospital management team that changes had been made to increase staffing arrangements. An increase of two extra escort staff had been introduced to allow the extra staff members to assist covering the ward environments and allowed where possible, planned leave to go ahead.

Records of staffing levels were provided in relation to all the wards at the hospital. These identified qualified and unqualified staff on the hospital wards. We saw that a patient had been admitted to an acute hospital and this required two staff members to accompany day and night. We saw staffing levels were constantly being reviewed and where necessary staff had been moved to other wards at the hospital due to unforeseen emergencies and issues on the wards.

We observed that a staff member had been allocated on each ward to undertake observation of the bedrooms and corridors whilst patients had access to their rooms. We were told that this was in place to make sure that patients are protected from the risk of other patients entering their rooms. Staff told us that by allocating a member of staff to the corridors upstairs on observations had reduced the number of staff that could spend time with the patients.

We were told by staff that on one particular ward there had been an increase in observation of patients. This had resulted in planned leave being cancelled or postponed, but this had improved as the level of patient observations on this ward had reduced.

Patients and staff told us that trips were cancelled but where possible these would be reinstated the next day.

Most staff we spoke to said that there had been improvements made by the hospital to increase the staffing levels and this had resulted in a reduction of cancelled leave for patients.

We looked at records and audits that had been produced by Arkwright ward. These showed us the system in place that recorded every patients leave, the date of their planned leave, the reasons for their trips and home visits. This included what the visit entailed as well as required staffing levels and cars required for the leave to go ahead.

Records were also being maintained hospital wide where leave had been cancelled, and records showed this was a result of staff shortage, cars not being available and reasons unknown. We were told that the auditing is taking place to look at future staffing levels where leave has had to be cancelled and this is to be reviewed by the hospital.

We were told that agency staff were not routinely used and where cover was required for the hospital their own bank staff were contacted in the first instance. Staff told that this was better for the patients if they already knew the staff, patients and the hospital.
Our judgement
People using the service are safe and their health and welfare needs are being met by sufficient staff to support people. There are processes in place to review staffing levels and patient need as a basis for deciding sufficient staffing levels. Systems are in place to review and respond to unexpected circumstances within the service.
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

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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<td>Patients told us that they want more communal activities on the lawns in front of the wards and to be outside more.</td>
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<td>We were also told that if a charitable event could be arranged on the lawn areas then maybe patients would want to get involved.</td>
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<td>Patients said the best part of their treatment was in the garden allotment area where they grew their own vegetables and they are looking forward to looking after the chickens.</td>
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<td>Patients told us that they wished the shop on site was open at the weekends as there was nothing to do at weekends.</td>
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<td>Patients told us they wanted coffee with caffeine reinstated into the wards. This area was discussed with the hospital managers who informed us that patients could purchase coffee with caffeine from the shop on site.</td>
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<tr>
<td><strong>Other evidence</strong></td>
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<td>The service sent us a copy of their Provider Compliance Assessment (PCA) as part of this planned review. The PCA submitted for this outcome identified that they were compliant for this outcome. It told us that there are a variety of measures in place to assess and monitor the quality of its service provision. There was a clinical audit program in place that was completed over a yearly period.</td>
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This included: The prevention of suicide, patient satisfaction in relation to their care programme approach meetings, patient satisfaction audit about what they think and where they live, complaints, documentation audit, staff survey, pharmacy and administration of medicines, patient satisfaction and what they have been told, seclusion of patients, patient satisfaction on their care and treatment, the management of violence and aggression.

We looked at the patient survey audits that had been completed and these had been summarised into a document, to be discussed at the governance meetings. We looked at the action plan that had been produced, however, this only addressed the lowest three satisfaction scores even though there were more highlighted on the patient survey. We were told the patient satisfaction surveys would be fed back to patients at the patients' council meetings.

We were told that a patient information pack had been produced as a result of a patient survey and these included information on the Mental Capacity Act, how to access their own health records and clinical notes, and information about the complaints process and other information leaflets. The hospital told us that these had been distributed to all patients in the hospital.

Within the hospital patients made representations and attended various patient focus groups. We looked at records of meetings that included a patient's food focus group and the patient council. Both of these groups were usually attended by a representative from each ward. These groups allowed patients to raise concerns, make suggestions for improvements and become involved in the induction of new staff into the service. We looked at the minutes of the meetings that had taken place and the action plans that had been produced; they told us who was responsible for taking the actions forward. The meetings currently take place every three months.

We looked at a patient survey feedback sheet in relation to food; we were told this was given to all patients in the hospital. The feedback sheet provided responses to all the patient ideas and suggestions in relation to the patient food survey.

**Our judgement**

People using the service benefited from safe quality care and support, due to effective decision making and good management of risk to their health, welfare and safety.
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
The provider is compliant with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
Some patients told us they knew how to make a complaint but this was not reflective of all the patients we spoke to.

A patient told us he had had some compact discs stolen from his room and reported this during our visit under the complaints procedure.

One patient on Wainwright ward told us he was not happy with the outcome of his complaint and he felt frightened on the ward. This was discussed with the ward manager who told us he would inform the patient of how he could take this forward and support him, and this would be addressed.

Other evidence
We visited all the wards and spoke to patients on various wards within the hospital. We looked at the complaints logs that were maintained in the ward offices. The complaints logs we looked at identified complaints were being recorded and resolved at ward level where possible. We were told the complaints recorded on each ward were presented to a staff member who was responsible for dealing with all the complaints for further analysis and investigation and response to the patients.

We visited the wards and did not find information displayed in all patient areas to inform patients how they could make a complaint. Although a staff member told us that all patients had received an information leaflet on how patients can make a complaint.
We looked at complaints that had been upheld or partially upheld by the hospital from March 2011 and August 2011. These complaints had all been acknowledged by the hospital manager and investigated. The complaints provided the individual patients with a response and the findings of the hospital investigation. The standardised response letter included contact addresses to inform patients of who they could write to, to appeal against the complaint if they were not happy with the outcome. The letters we looked at told us a report of the complaints was provided monthly to the hospital senior management team. Where lessons were learnt from the complaints, this was shared across the hospital. The responses made to individual patients acknowledged that if the patient had any concerns or needed assistance to appeal against the response to their complaint they could speak with an advocate or staff member at the hospital.

Our judgement
There were effective systems in place to deal with complaints and patient complaints are acknowledged and investigated.
Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 02: Consent to care and treatment</td>
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<tr>
<td><strong>How the regulation is not being met:</strong></td>
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<td>Outcome 07: Safeguarding people who use services from abuse</td>
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| Outcome 09: Management of medicines | |
| Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 | How the regulation is not being met:  
People who use the service were not always protected against safe and suitable premises. The premises were not being adequately maintained and the appropriate measures were not in place to address environmental risks identified. |
| Outcome 10: Safety and suitability of premises | |
| Regulation 15 HSCA 2008 | How the regulation is not being met:  
Diagnostic and screening procedures | |
| Outcome 10: Safety and suitability of premises | |
The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
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

<table>
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<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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Care Quality Commission

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