Requires improvement

Coventry and Warwickshire Partnership NHS Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RYG12	Brooklands Hospital	Amber ward	B37 7HL
RYG12	Brooklands Hospital	Jade ward	B37 7HL
RYG12	Brooklands Hospital	1 Tuxford Avenue	B37 7HL
RYG12	Brooklands Hospital	3 Tuxford Avenue	B37 7HL

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated wards for people with learning disabilities or autism as requires improvement because:

- The service had not identified ligature risks and blind spots areas on the adolescent wards, particularly in unsupervised areas.
- The adolescent wards at Tuxford Avenue and Jade ward had high levels of staff vacancies and, whilst regular staff filled vacant shifts, this increased the workload for regular staff.
- Staff did not always ensure that medications were stored and administered safely. Staff were using four bottles of medication that were out of date and left medication on the side that was not secured. Staff could not account for this.
- Staff restrained patients frequently between June and November 2015, this included restraint in the prone position (face down). Patients positive behaviour support plans did not state patients preferred to be restrained face down. Doctors did not attend medical reviews following restraint as required by trust policy and the Mental Health Act code of practice.
- Mandatory training compliance was low at 58%. 78% of staff had received safeguarding vulnerable adults and children training.
- Mental Health Act, Deprivation of Liberty (DOLS), and Mental Capacity Act training was mandatory for qualified staff; however, unqualified staff could request to attend training. The attendance at this training was significantly lower than the trusts target of 95%. 88% of staff on Amber ward had received training, 52% of staff on Jade ward and 63% of staff at Tuxford Avenue wards.
- Staff we spoke with on the adolescent wards did not understand Gillick competence and consequently did not have the knowledge and skills to assess capacity of children under the age of 16. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.
- Staff did not receive regular supervision in line with trust policy, so were not receiving the appropriate support and management review of performance to carry out their role.
- Staff told us morale was particularly low on Jade Ward.

However:

- Staff completed comprehensive risk assessments, which indicated how patients wanted to be treated when in distress and how any aggressive or challenging behaviour should be managed. This demonstrated that patients could be involved in their care, even at times of acute distress.
- A review of prescribing concluded that medical staff prescribed medications in line with NICE guidance and regularly reviewed their practices and adapted to changes in the guidance.
- Psychological therapies such as behavioural therapy, was offered to patients in line with the National Institute for Health and Care Excellence (NICE) guidance.
- Easy read material was accessible and available. This included posters informing patients how to complain, care plans, positive behaviour plans, weekly menus, therapy programmes, and pictorial emotional boards to support patients unable to verbally express their feelings.
- Staff supported all patients to have Section 17 leave to local community activities, with appropriate support. This enhanced patients' lives and promoted recovery.
- Staff could request additional training to support patients with different communication needs.
- Admission and discharge planning was innovative, creative and gradual. This recognised the needs of the patient group to support smooth discharge to further placements, whether that was at home, another hospital or community.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff did not identify all ligature points and blind spots on the adolescent wards. Consequently the trust had not taken measures to mitigate these risks.
- The adolescent wards (1 and 3 Tuxford Avenue) and Jade ward had high levels of staff vacancies and, whilst regular staff filled vacant shifts, they were not receiving supervisions to support well being and practice. Staff reported that morale was low on Jade ward due to the high turnover of staff and work load.
- Data showed that between June and November 2015 staff restrained patients frequently, this included restraint in the prone position (face down). Doctors did not attend medical reviews following restraint as required by trust policy and the Mental Health Act code of practice. 59% of staff across the services had completed management of actual or potential aggression (MAPA) refresher training. Of 115 staff eligible for the refresher training 68 had received it. Of the 31 members of staff eligible for MAPA holding and disengagement foundation refresher, 13 members of staff had received the update. Consequently we were not assured that staff had the skills necessary to manage aggressive incidents, de-escalate potential aggressive situations, and consider the least restrictive option for managing patients.
- Staff did not always ensure that medications were stored and administered safely. Staff were using four bottles of medication that were out of date and left medication on the side that was not secured. Staff could not account for this.
- Tuxford Avenue and Jade ward were below the trusts target for mandatory training.

However:

- The trust had ensured that Amber and Jade ward had been fitted with anti-ligature furnishings, and where there were ligature risks, they had identified the level of risk and mitigated these.
- 78% of staff across the inpatient wards were up to date with safeguarding children and vulnerable adults training.
- The trust complied with single sex accommodation regulations on all wards.
- Clinical rooms had appropriate and accessible emergency resuscitation equipment which was regularly checked.

Summary of findings

- Staff carried out comprehensive risk assessments, positive behaviour plans, observation levels, and safely plans in collaboration with patients. Observation policies were in place and staff recorded observations correctly.
- There were effective systems for reporting, recording, and reviewing incidents.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Mental Health Act, Deprivation of Liberty Safeguards, and Mental Capacity Act training was mandatory training. A low percentage of staff had completed this training with the compliance rate at 58%. Staff on the adolescent wards at Tuxford Avenue did not understand the Gillick competence and consequently did not have the knowledge and skills to assess capacity.
- Staff on Tuxford Avenue and Jade wards did not receive regular supervision which meant that staff had not received the necessary support to carry out their roles.

However:

- Patients had comprehensive and holistic care plans and positive behaviour plans.
- Patients received regular physical health care checks and there was a physical health nurse based across the four wards.
- Medical staff had correctly completed capacity forms for patients detained under a Section of the Mental Health Act, 1983, and these were kept with medication administration, recording sheets (MARS) and audited weekly with medications to ensure accuracy.
- Medical staff used NICE guidelines for prescribing and had recently reviewed the use of some medication due to changes in guidance for treating people with learning disability.
- Patients received psychological therapy in line with NICE guidance.
- Staff had developed good links with the local general hospital and a named neurologist who managed the needs of patients with epilepsy.
- Unqualified staff had opportunities to undertake a national vocational qualification in care, which could eventually lead to secondment to take a foundation degree and nurse training.
- Staff could request additional training to support patients with different communication needs.

Summary of findings

Are services caring?

Good

We rated caring as good because:

- Staff respected patients' rights to privacy and dignity and sought permission during care interventions.
- Patients were admitted to the wards in a caring manner and with considerable planning. Consequently stays on the ward started in a positive way.
- Staff listened to patients and used appropriate forms of communication to ascertain their thoughts and feelings when these were not easily expressed.
- We saw kind, caring and positive interactions between staff and patients on all the wards.
- Patients told us that staff were nice and would engage with them in the way they wanted, for example, when playing a game.
- Relatives told us that staff were caring and had patients' best interests at heart. Patients told us staff supported them to keep in contact with their family. Dedicated areas for patients to meet their visitors were available.
- Advocates attended the ward weekly, including a named child advocate for patients admitted to the adolescent ward.
- When patients were unable to be fully involved in planning care, staff would include relatives in the planning process.

However:

- Some patients told us they were not allowed a copy of their care plan. Staff explained that in some cases this would be inappropriate due to a patient's needs. We did not however see this assessment documented within care plans.
- Staff had not considered whether those patients under the age of 16 were Gillick competent before sharing information about them to parents.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The wards had a strict policy not to admit to beds when patients were on leave, so that patients could return immediately and without fear of losing their bed.
- Patients moved between wards if there was a clinical need and this would be carefully planned with the patient.
- The service admitted patients from across the country because this service is a national service and there may not be specialist services in the patient's local area. Discharge planning was innovative and person centred.

Summary of findings

- There was a psychiatric intensive care unit accessible on site, however, staff worked hard to nurse patients in the least restrictive environment, even if this meant increasing staffing levels.
- Staff supported and encouraged patients to take their Section 17 leave.
- Patients could use the kitchen areas under supervision to make snacks and drinks.
- The wards had a variety of spaces for patients to access, including quiet rooms, television lounges, and pleasant outdoor areas. Wards had age appropriate play equipment available for patients to enjoy and these were regularly checked and cleaned. We saw a range of activities and saw evidence that patients were taking part in these.
- Easy read material was accessible and available, including menus, care plans and the complaints procedure.
- Patients were supported to personalise their bedrooms. Educational services were on site so that adolescents could attend school.
- Ward areas had good disabled access.
- The adolescent ward staff held weekly house meetings to discuss the running of the ward.

However:

- All patients we spoke with told us they did not like the food, although the trust was working with patients to improve this.
- All patients we spoke with told us they were bored.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff had not received supervision in line with the trust guidelines of once a month.
- There was a high level of staff vacancies across the four wards, and in particular Jade ward had experienced a high level of staff turnover in the previous six months. Staff reported morale was low.
- There was higher than expected sickness levels on Jade ward and Tuxford Avenue. The trust aimed to achieve sickness under 4.5% but Jade ward had a 7.6% sickness level between December 2014 and December 2015. It was unclear how these had been addressed and whether the increased workload had been considered when regular staff covered a high number of vacant shifts.

Summary of findings

- The trust expected 95% compliance for mandatory training, but the inpatient wards each fell below this threshold. Across the wards 58% of staff were up to date with mandatory training.
- 52% of qualified staff on Jade ward had received Mental Health Act and Mental Capacity Act training. This training was not mandatory for unqualified staff that worked with patients daily. However, they would need to have a good understanding of capacity and consent.
- Amber and Jade wards admitted a similar patient group, yet they did not work together to improve standards and share ideas.
- The trust had identified high levels of restraint and prone restraint used in 2014 and had completed an action plan to reduce this. A review of the action plan in 2015 identified that some recommendations had not been actioned, and some only partially actioned. This included doctors to visit patients who had been restrained within two hours and for staff to explore alternative restraint methods. However, at the time of inspection we noted that doctor reviews were still not taking place and there had still been a high level of use of prone restraint, in particular on Amber ward.

However:

- The staff knew the trust's visions and values which were displayed on the wards and discussed these during yearly appraisals.
- Senior managers had visited the wards and staff knew who the senior management team was.
- Ward managers had the authority to increase staffing levels based on needs of the ward.
- Staff carried out clinical audits which were reviewed by ward managers and results were fed back during team meetings if improvements were needed.
- The trust shared information about lessons learnt from incidents with staff. These were fed back to staff through a shared computer drive, a paper trust wide update and handovers, supervisions and regular staff meetings.
- Ward managers held weekly formulation meetings so that staff could contribute to changes in patients care.
- Staff had opportunities to develop. Ward managers could undertake leadership training and unqualified staff could be seconded to achieve national vocational qualifications, a foundation degree and following on from this a nursing degree.

Summary of findings

Information about the service

The learning disability inpatient services are based at Brooklands hospital, in Marston Green. Brooklands hosts a specialist assessment and treatment service (SATS). Brooklands inpatient services are based over four wards, providing care, and treatment for people who have a learning disability and severe mental health and behavioural problems. Amber and Jade wards support working age adults, whilst 1 and 3 Tuxford Avenue, provide services to adolescents. The service accepts patients from across England.

The adults service is based over two wards:

Amber Ward has 12 beds, with separate facilities for males and females, with capacity to offer up to three enhanced care suites. Enhanced care suites are for those individuals who present with a higher level of challenging behaviour, levels of disturbance and mental health problems. This ward was compliant with single sex accommodation requirements.

Jade Ward has 15 beds, with separate facilities for males and females between the ages of 16-25, who may display difficult and challenging behaviours and have mental health issues. Some may also have committed offences. This service also supports the young person during the transitional period from adolescence to adulthood. Of these 15 beds, 10 are designated as a specialist young person's unit for persons between the ages of 16-25.

The adolescent service is based in two separate wards at Brooklands:

1 Tuxford Avenue - 6 bedded assessment/treatment area

3 Tuxford Avenue - 6 bedded assessment/treatment area

The adolescent service provides comprehensive inpatient assessment and treatment for adolescents who have a learning disability and other associated mental health and behavioural problems. The wards provide treatment packages, which include access to education, for individuals aged from 12 to 19 years old. Patients present with a wide variety of different behaviours as a result of environmental, psychiatric and neurological difficulties that cannot be managed in their home or school settings.

Our inspection team

Our inspection team was led by:

Chair: Paul Jenkins, Chief Executive, Tavistock and Portman NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, (mental health) CQC

Inspection Manager: Margaret Henderson, Inspection Manager, mental health hospitals CQC

The team that inspected the inpatient learning disabilities services consisted of two inspectors, four specialist advisors and an expert by experience.

The team would like to thank all those who met and spoke with the team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information, and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- Visited four wards, looked at the quality of the ward environment, and observed how staff were caring for patients.
- Spoke with eight patients who were using the service.
- Spoke with two relatives.
- We interviewed three managers and one acting manager for each of the wards.
- Spoke with 15 other staff members, including doctors, nurses, and health care assistants.
- Looked at ten treatment records of patients.
- Carried out a specific check of the medication management on four wards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients who used the service told us that they felt safe and that staff were caring and compassionate.

Patients at the service told us they were bored, and that there were not enough meaningful activities. They also told us that they did not like the food at the service, although the trust was making efforts to engage with patients to address this. The service held monthly meetings so that they could people at the service could suggest changes to menus.

Relatives told us that staff knew patients well and worked with them to manage their complex needs and behaviours. They told us that staff would respond to concerns quickly and this assured them that their relatives were safe. There were no patient satisfaction surveys available for the four wards.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure ligature risks are identified, assessed and risks to patients are mitigated appropriately. Staff must be aware of any risks and how they are managed.
- The trust must ensure that all staff have the necessary training to ensure that patients' rights are protected in relation to the Mental Health Act 1983, Mental Capacity 2005, and Gillick competence. The trust must ensure that staff have received the required mandatory training in line with trust policy and guidelines.
- The trust must ensure prone restraint is reduced and medical reviews are completed as per policy.
- The trust must ensure they provide sufficient staff to care for patients safely.

The trust must ensure that staff receive regular supervision in line with their own policy and procedures.

Coventry and Warwickshire Partnership NHS Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Amber ward	Brooklands Hospital
Jade ward	Brooklands Hospital
1 Tuxford Avenue	Brooklands Hospital
3 Tuxford Avenue	Brooklands Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act (MHA) 1983. We use our findings as a determiner in reaching an overall judgement about the trust.

- Qualified staff had a good understanding of their responsibilities under the Act. However, unqualified staff had limited knowledge and were not required to have training. The trust had not ensured that those staff subject to mandatory training under the Act had received the appropriate updates. Training compliance was poor, with 58% of staff across the four wards having received the training.
- Medical staff had correctly completed, and reviewed consent to treatment plans documentation (T2 and T3) for patients detained under a section of the Mental Health Act, 1983. These were correctly kept alongside patients medication cards.
- Staff explained to patients their rights under the Mental Health Act (MHA) and explained these at regular intervals. This included the right to appeal against their section.
- The trust had administration support and legal advice on implementing the MHA and staff knew whom to contact if they had any questions.
- Staff and consultants completed detention paperwork correctly, for example regularly reviewing patients' section 17 leave status and ensuring that paper work reflected this. Section 17 leave is leave from hospital granted by the consultant on either an escorted or an unescorted basis.

Detailed findings

- The MHA administrator regularly reviewed all MHA documentation to ensure that it was up to date. Although they had not identified that one person on one of the wards had not been read their rights. Staff rectified this once we informed them.

Patients had access to Independent Mental Health Advocacy (IMHA) services. The information about these services was displayed in easy read format and staff informed patients and relatives about this service during reviews.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training was mandatory for qualified staff, and was combined with Mental Health Act training. However, it was not mandatory for unqualified staff. Only 58% of staff had received this training.
- The trust made appropriate referrals under DoLS for Amber and Jade wards. On both Amber and Jade wards, two patients had been subject to DoLS, all had been granted.
- Unqualified staff did not have a good understanding of capacity which would inform whether a patient had the ability to consent.
- Patients on both Amber and Jade wards regularly had capacity assessments completed related to specific decisions. These were carried out by qualified nurses and doctors on the wards and these were kept in patients' files alongside the patients' integrated treatment plan.
- Staff on Tuxford Avenue adolescent wards had not always appropriately assessed patients' capacity. Staff did not have an understanding of Gillick competency. When decisions of lack of capacity had been decided, there was no evidence about how staff had arrived at decisions. For example, they had not carried out capacity assessments which would include the patients, relatives, and advocates.
- We saw that access to advocacy services was readily available to patients and their parents. A named children's advocate attended the ward regularly.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Bedroom areas on Jade and Amber wards were not easily visible from the day area. Blind spots had not been mitigated with mirrors; however staff were always in the day area-observing patients, and would regularly monitor the corridor areas. At Tuxford Avenue there were blind spots upstairs. They did not have mirrors or closed circuit television. However they used a monitor to listen when patients were upstairs.
- On Jade and Amber wards, all bedrooms and bathrooms had anti-ligature taps, door, and window handles. All bedrooms were free from ligature points. There were some ligature points in the communal areas. There were retaining arms on the doors that were ligature risks. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. However, the trust mitigated this by having staff in the communal areas at all times to monitor this. The trust had completed regular ligature audits and risk assessments that covered these risks. These rated all ligature points as high, medium, or low risk. There was also an explanation as to what the trust had done to mitigate the risk such as door handles that had been changed on Amber ward.
- However, at Tuxford Avenue, there were ligature points in the bathrooms which the patients used unsupervised. This posed a risk to patients on these wards as ligature points are considered higher risk for patients if in places where time is spent without direct supervision by staff.
- The trust adhered to same sex accommodation guidelines. All wards had separate male and female lounges and bedroom areas.
- Clinic rooms on Jade and Amber wards were both well equipped with accessible resuscitation equipment which was regularly checked by staff so that they could respond quickly if this was needed. Emergency equipment audits showed staff regularly checked equipment was clean and in working order. The trust had all electrical equipment portable appliances tested for safety. There were first aid boxes in each clinic room that were well equipped. The staff regularly checked these and ordered supplies as necessary.
- The medication cupboards on Jade ward were dirty and in need of cleaning. We raised this with staff who took immediate action. The CQC pharmacy inspector returned the following day and found that staff had addressed concerns over cleanliness.
- The trust was refurbishing the seclusion room on Amber ward at the time of inspection. The room had been fitted with a toilet and shower area that would be easily visible, but that would also respect patient's privacy and dignity. The room was temperature controlled, with a two-way communication system in place, to ensure that staff could safely monitor patients. Jade ward and Tuxford Avenue did not have a seclusion room, and staff managed violence and aggressive behaviour through positive reinforcement and de-escalation. There was a quiet room available where patients could be escorted to calm down, with support by staff. This room was used as a safe space and patients could leave at any time.
- All ward areas were clean and tidy. We checked all the cleaning rotas, audits, and staff had completed these correctly. The decoration was in good condition. We saw that furnishing on all of the wards was in good condition, and staff told us that each ward kept a maintenance record so that they could keep track of reporting items that were broken or needed repair.
- Staff on all wards adhered to infection control principles when supporting patients with personal care needs. There were hand-washing facilities for staff to use, including alcohol gel. There were adequate contaminated waste bins throughout all wards. Staff followed the infection control policy in disposing of contaminated waste by placing it in the appropriate bin. We checked the health and safety audit which contained infection control questions. Staff completed this on a three monthly basis. This showed that staff identified issues and they took action to correct these.
- The staff had access to pinpoint alarms. This allowed them to summon assistance when they were in a situation where they felt at risk. A member of staff would be assigned on each ward to respond to alarms so that other staff could remain and support other patients.

Requires improvement

Are services safe?

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

Staff could identify the location of the alarm by looking at panels located in all areas of the ward. The trust had spare alarms which they used for visitors. Staff provided us with alarms prior to entering the ward. Staff told us that alarms were checked regularly but it was their own responsibility to check these were working. We did not see evidence that this monitored or checked.

Safe staffing

- All wards had a high number of qualified nurse vacancies. Jade ward had an agreed establishment of 13 qualified nurses and 25 nursing assistants. In November, the trust reported they had three qualified and four unqualified vacancies. At the time of inspection this had increased to six qualified nurse and two health care assistant vacancies. This equated to almost half their total staffing establishment. Staff told us the high turnover of staff had affected their morale. The service did not often use agency staff, using regular staff on bank to fill the vacant shifts. Staff on Jade ward had experienced higher levels of sickness than expected. Between December 2014 and November 2015, there had been a 7.6% sickness rate, compared with the estimated 4.5% by the trust. For the same period, Jade ward had experienced the highest level of turnover of staff over the four wards at 17.6%. They also had a new ward manager who had been in post for six months.
- Amber ward had an agreed establishment of 12 qualified nurses and 24 nursing assistants. At the time of inspection there were four qualified nurse vacancies and four nursing assistant vacancies, equating to a third of the staffing establishment. Again, agency staff were rarely used, with regular staff filling vacant shifts on bank duty. Staff on Amber ward reported good morale. Sickness levels were below expected at 3.5% and staff turnover, as reported in November, was 11.8%.
- Tuxford Avenue had a total establishment of eight qualified staff and 22 nursing assistants. However, at the time of inspection they had six qualified staff vacancies and 10 nursing assistant vacancies. This equated to just under half the established numbers. However, there were four patients on the wards and staffing levels reflected of this. Regular staff filled the vacant shifts on bank, and this gave some consistency of care to patients on the ward. Agency staff were used infrequently and we saw that when they were used they were inducted to the ward appropriately, and supported by regular staff. Sickness levels were higher than the trust target of 4.5% at 6% and staff turnover for the same period of December 2014 to December 2015 equated to six members of staff leaving.
- Ward managers were able to adjust staffing levels dependant on the needs of the patients. The managers would regularly increase staffing levels to support patients to have Section 17 leave. The managers would also increase staffing to manage higher observation levels. On the day of inspection, Jade and Amber wards staffing levels had been increased to manage patients on increased observation levels.
- Patients told us their leave was not cancelled due to staffing issues. Staff planned leave in advance so that extra staff could be arranged to manage this. Patients also told us that they were able to have regular one to one time with the nursing time should they need it.
- The service had adequate medical cover day and night and a doctor would attend the ward quickly. Two consultant psychiatrists covered the four wards. Junior doctors worked with them and were available during the day. The trust had an on call system for out of hour cover. The junior doctors worked on a rota system to provide cover out of working hours. There was also an out of hour rota for consultant psychiatrists.

Assessing and managing risk to patients and staff

- There were 174 episodes of seclusion between April and November 2015. All of these were on Amber ward.
- The service had not taken measures to reduce the high number of restraints and use of prone restraint. Prone restraint can be defined as a person being restrained face down. Prone restraints can result in asphyxiation. Staff on all wards told us they used restraint as a last resort when de-escalation failed. If a patient became aggressive staff would respond as set out in a patient's positive behaviour support plan. However, there were 581 episodes of restraint across all the wards between June and November 2015. These were highest on Amber ward where prone restraint had been used 92 times. We did not see sufficient evidence that when prone restraint was used this had been justifiable on the grounds of 'exceptional circumstances'. None of the patient's positive behaviour support plans stated that patients preferred to be restrained face down. At the time of inspection we did not see evidence that medical reviews had been implemented following use of prone restraint, as stipulated in the trust policy. However, staff told us

Requires improvement

Are services safe?

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

that if a patient was restrained in the prone position for any length of time a qualified nurse would monitor the patient's vital signs to make sure they were not at risk of positional asphyxiation.

- Staff on all four wards staff wrote detailed and comprehensive risk assessments for each patient upon admission. Staff used the risk assessment tool on the trust's computerised record system. Staff also documented risks in patient's positive behaviour support plans as well as within their care plans. These covered both current and historic risks. Staff regularly reviewed risk assessments and updated them as necessary. There was evidence of patient involvement in assessing risks. For example, as part of the patients positive behaviour support plan they discussed how they would like staff to react should they become agitated or aggressive. This included how they preferred to be restrained such as in a sitting position or lying down. Staff regularly reviewed risk assessments after incidents.
- The trust had policies in place for the use of observations. Staff used different levels of observations depending on patient risks. They used general observation, intermittent checks, one to one in eyesight, and one to one in arms reach. Patients were involved in planning these observations if appropriate, and we saw this reflected in patients' positive behaviour support plans. Staff documented this in the patients' notes and reviewed this regularly as part of ward round.
- 59% of staff across the services had completed management of actual or potential aggression (MAPA) refresher training. Of 115 staff eligible for the refresher training 68 had received it. Of the 31 members of staff eligible for MAPA holding and disengagement foundation refresher, 13 members of staff had received the update. Consequently we were not assured that staff had the skills necessary to manage aggressive incidents, de-escalate potential aggressive situations, and consider the least restrictive option for managing patients.
- Staff stored medications in locked cupboards in the locked treatment rooms on each ward. However, on Jade ward we saw that the medication cupboard was dirty, and we found that staff had left an injection drawn up in a syringe in the cupboard with the medication bottle left open. Staff could not account for why this was there. Consequently we could not be sure that medications were always stored safely.
- Staff stored medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely. Medicines requiring cold storage were kept in locked refrigerators in the treatment rooms. Staff monitored the temperature of these and the records were all up to date and knew what to do if the temperature was not within range.
- Medication audits at Tuxford Avenue had not identified four medicines being available for administration after their expiry date. The pharmacist who visited fortnightly to order new medication and dispose of old stock had not identified this. We could not find records that medications had been checked. The pharmacist inspector highlighted these medications to staff who disposed of them appropriately.
- There was a blanket restriction around smoking. Patients were restricted at certain times during the day when activities were scheduled and there was no smoking at night. Staff told us this was to promote engagement in the therapeutic programme as well as promoting healthy living.

Track record on safety

- We saw that the trust was reporting serious incidents to the appropriate safeguarding authorities. There were three serious incidents requiring investigation across all wards in the past year. These included issues such as violence and aggression and allegations of abuse. The trust has investigated these with one investigation outcome pending.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to report incidents. They were able to describe what sort of incidents they should report such as near misses, falls, violence, aggression, and safeguarding incidents. We saw that staff used an incident reporting book to record incidents, and put copies of these forms in patient records. Copies were given to the ward managers, and sent to the trust risk management department for monitoring.
- Staff learned from incidents. The trust sent out lessons learned bulletins and staff displayed these on the wards. There was also local feedback from managers through team meetings and staff supervision. Managers also provided Information to staff in paper format to read. Following incidents staff would hold meetings in which

Requires improvement

Are services safe?

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

they discussed different ways to manage complex patients. Following these meetings staff would share the information through handover meetings and multi-disciplinary team meetings.

- The trust had changed their medication ordering protocol following an incident when a staff could not obtain medication for a patient on a Friday. Staff were now expected to order medication before Friday, and in emergencies they would contact the on call pharmacist who supported staff to obtain the medication needed.
- Staff and patients were supported following serious incidents. Staff received debriefing after incidents. A debrief is an opportunity for people to talk about what happened, offer support to each other and discuss how to improve and mitigate similar risk occurring. This would either be one to one or in a group. The manager told us they could also refer staff to occupational health or to "Cope", which is a counselling service the trust used. Staff offered debriefs to patients following incidents who would spend one to one time with their named nurse to discuss the incident and what those involved could have done differently.
- Patients received a debriefing after being restrained. We saw evidence in notes that staff had spent one to one time with patients to support them once the restraint and period of aggression had resolved. Staff received a debrief following restraints during weekly formulation meetings and not necessarily on the day of restraint. During the formulation meetings staff would discuss what had happened and how to minimise the risk of restraint and positive behaviour plans would updated if appropriate.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- Patients received a comprehensive assessment of their needs prior to admission. Staff would visit patients prior to admission to assess their appropriateness for admission. Staff completed thorough assessments that covered past history, family history and presenting risks. Staff discussed the information from these assessments within multi-disciplinary team meetings. During these meetings staff made a decision whether to admit. Staff considered whether the patient met the criteria for admission and also the current mix of patients and how the new patient would fit in. Once staff decided a patient was appropriate for admission, there was an ongoing period of assessment. This could take several weeks due to the complex nature of patient's needs. During this time staff took time to get to know the patient and assess their needs and information would be used to update the care plan.
- Patients received a physical examination upon admission. We found that staff monitored physical health on a regular basis. This included monitoring blood pressure, heart rate, and any other physical health checks they needed such as weight, using the Malnutrition Universal Screening Tool (MUST). Patients had health action plans in their files that provided details about the physical health issues a patient has and what treatment they are receiving. Epilepsy support plans were in place that detailed how staff should care for patients who suffer from epilepsy. These were individualised and showed patient involvement in deciding how staff manage their seizures.
- Staff wrote detailed and comprehensive care plans and positive behaviour support plans for patients. We looked at 10 care records. These contained care plans covering a range of needs and were holistic, personalised, and up to date. Staff on Jade and Amber wards involved patients in writing their care plans, and staff documented patient views throughout.
- Staff ensured that patient's notes were stored safely and that confidentiality was maintained. Paper records to document patient's care were kept in the nursing office in locked filing cabinets. Staff kept the nursing office locked. These records were available to all staff including bank and agency staff. If patients moved ward the staff transported the records to the new ward in secure bags.

Best practice in treatment and care

- Following a review of prescribing we concluded that medical staff used National Institute for Health and Care Excellence (NICE) guidelines when prescribing medication. We spoke with medical staff that were able to explain about recent updates from NICE regarding the prescribing of controlled drugs. One such update was in regards to the prescribing of midazolam, which staff use to treat patients with epilepsy.
- Patients had access to psychological therapy recommended by NICE. Staff could refer patients to the psychology service within the hospital. Psychologists provided assessments and used the information to decide the appropriate therapy. These include functional and behavioural assessments. The psychologist wrote case summaries and supported staff and patients to write their positive behaviour support plans.
- The trust had two physical health care nurses on the hospital site. Patients we spoke with told us that they are having their physical health monitored regularly. There was good links with specialists at the local general hospital and they had a named neurologist work with for patients with epilepsy, and we saw that appointments and advice were sought by staff when a patient needed it.
- Staff used Health of the Nation Outcome Scales (HoNOS) to monitor and assess patient progress and outcomes. Staff recorded these in the patients' care records.
- Ward staff carried out audits to ensure that care records, care plan's and risk assessments were up to date. This meant that changes and updates were identified the keyworker would update these with the patient.

Skilled staff to deliver care

- Multi-disciplinary team meetings took place on each ward every week. These meetings were attended by all staff disciplines. During these meetings patients' care was discussed along with any recent incidents, including what staff could have done better and any lessons learned.

Are services effective?

Requires improvement

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

- All staff we spoke with described good working relationships amongst the team. They worked well as a team and communication was good. Staff on Jade and Amber ward said that as they admit nationally it could be difficult to develop good working relationships with teams outside of their area. This made it difficult when planning discharge and finding placements for patients to move to.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary team meetings took place on each ward every week. These meetings were attended by all staff disciplines. During these meetings patients' care was discussed along with any recent incidents, including what staff could have done better and any lessons learned.
- All staff we spoke with described good working relationships amongst the team. They worked well as a team and communication was good. Staff on Jade and Amber ward said that as they admit nationally it could be difficult to develop good working relationships with teams outside of their area. This made it difficult when planning discharge and finding placements for patients to move to.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Qualified staff on all wards received training on the Mental Health Act code of practice. This training also included sections on the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust had updated their training to include changes to the Mental Health Act code of practice. Qualified staff received this as part of their mandatory training, and staff we spoke with demonstrated a good understanding of patients' rights held under the Mental Health Act. This was particularly evident on Amber ward, where 88% of staff had been trained.
- However, whilst this training was available for unqualified staff, it was not mandatory. Only 52 % of staff on Jade ward had received training, and 69% of staff at Tuxford Avenue. It was evident in interviews that unqualified staff did not have a clear understanding of the rights of detained patients. Staff told us that if there was any questions, or concerns around a patient's rights, they would discuss these with qualified staff. We did not see any information about informal patients' rights.
- Medical staff had correctly completed, and reviewed consent to treatment plans documentation (T2 and T3) for patients detained under a section of the Mental Health Act, 1983. These were correctly kept alongside patients medication cards.
- We saw evidence that staff informed patients, detained under the Act, of their rights and restrictions, including the right to appeal. Staff completed the appropriate documentation to evidence this.
- A Mental Health Act administrator audited all MHA forms regularly to ensure that there were no inaccuracies. However, we saw that on Jade ward, a patient had not received their rights. There was no documentation why they had not been informed. Staff rectified this when we told them about it.
- Amber ward had governance systems to audit that staff adhered to the Mental Health Act code of practice. Staff ensured that detention paper work was filled in correctly, both on admission and afterwards.
- Patients were supported to access Independent Mental Health Advocates (IMHA).

Good practice in applying the Mental Capacity Act

- Knowledge and understanding of the Mental Capacity Act varied across the inpatient services. 88% of staff on Amber ward had received training on the Mental Capacity Act. Staff knowledge was evidenced in staff interviews and patient notes. However, Jade ward had achieved 52% of staff trained in this area. This lack of knowledge was reflected in staff interviews. Qualified staff received mandatory training on the Mental Capacity Act 2005, for unqualified staff training was not mandatory which meant that unqualified staff had a limited understanding of capacity. Consequently this meant that they might not be able to identify a capacity issue and act appropriately to protect patients' rights.
- At Tuxford Avenue, a child, and adolescent ward for people with learning disabilities, staff we spoke with did not have a good understanding of Gillick competency. Only 69% of staff on Tuxford Avenue had received Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) awareness training. We could not find evidence in the care records that Gillick competency assessments had taken place. This meant that staff did not have the knowledge to competently address capacity issues for children under the age of 16.
- We saw that access to advocacy services was readily available to patients and their parents. A named

Are services effective?

Requires improvement

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

children's advocate attended the ward regularly to see if any advocacy support was needed, and the communication board in the patient area detailed the advocates name and contact information. Staff did not however monitor how often advocacy support was used, so we could not be certain whether it had been offered to patients appropriately due to limited understanding of capacity and Gillick competency.

- Doctors and qualified staff undertook mental capacity decision specific assessments which were kept in patients' files alongside the patients' integrated treatment plan. These were appropriately assessed and we saw that the decisions made had included other professionals, and relatives when appropriate.
- Staff on Amber and Jade wards, had applied the DoLS appropriately, with all applications being accepted by the local authority. We saw that the correct paperwork was completed and staff had systems in place to ensure that any deprivation of liberty would be reviewed within the appropriate time frame.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Staff respected patients' dignity and treated patients with respect. Patients told us that staff always knocked before they entered their bedrooms and that they respected patients' personal space. However, some relatives told us that there was an issue of patients' clothes going missing and they had had to request staff look for these which meant a lack of respect for patients' belongings. When this issue was raised with staff, staff attempted to locate the lost items.
- Staff were observed to be kind and caring in their responses to patients on the wards. One patient told us that staff did not speak to them and were uncaring, however we observed positive interactions between this person and staff. Other patients told us that staff were nice, and one patient told us that staff were nice and played the play station with them.
- Staff at the service reinforced positive behaviours to support patients' recovery. When patients became distressed and aggressive, staff would try and minimise distress and risk by using de-escalation techniques. This involved listening and communicating with patients calmly to reduce their agitated and aggressive behaviour, without need for restraint. We saw that staff engaged with patients well.
- Patients and relatives told us that staff were respectful and supportive. One relative stated that staff really seemed to care and knew what was best for their relative. Another said that staff were very friendly and approachable.

The involvement of people in the care that they receive

- Staff admitted patients to the ward in a caring manner. Patients were shown around the ward and introduced to staff and other patients at the service, if appropriate at the time of admission. For example, if the patient was not in distress or agitated.
- Staff on all wards told us they tried to involve patients in all aspects of care planning. Easy read care plans were in place for patients, although we did not see that patients had ready access to these. Five patients told us they had not seen their care plans and were not allowed a copy of them. They all told us that care plans were locked in the nursing office. One patient said they were not allowed a copy of their care plan and did not know why. Staff told us that they did not give care plans to everyone because some patients would become distressed by them, or would not understand them. However, this was not always clearly stated in care plans to indicate how patients had been included in other ways to plan their care. However, one relative told us their relative did not understand information given to them but staff always tried and sat down with him to help them understand the information.
- Staff ensured that families and carers were appropriately involved in planning care for patients who lacked capacity. Relatives told us that they were involved in all aspects of care planning and they would be invited to care reviews. Those relatives we spoke with told us that following care reviews, care plans would be updated and shared with them. However, staff at Tuxford Avenue had not considered Gillick competency of patients under the age of 16. Consequently they had not considered whether patients in this group had capacity to make decisions about who they wanted to be included in planning their care.
- Some patients we spoke with did not know what advocacy services were, and said they had not been offered advocacy support. However, staff told us that advocates attended the ward and ward reviews when appropriate. Relatives told us they were aware of advocacy services and how to access them.
- Amber and Jade wards held monthly community meetings, chaired by patients on the ward. However, these were not well attended, and patients told us they were fed up of chairing the meetings which they felt were pointless.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The trust admitted patients to the learning disability inpatient wards from across the country. This was because there may not be specialist inpatient wards of this nature in their local area. All wards had less than 100% occupancy. On Amber ward 67% of beds were occupied. At the time of inspection the trust had deliberately kept some beds vacant due to the existing level of needs that patients had on the wards, and to ensure that patients had the appropriate level of support. However, in the event that a person needed emergency admission, the trust ensured that medical staff considered whether a potential admission was appropriate, giving consideration to the existing patients on the wards.
- The trust had a clear policy not to admit new patients into leave beds. This ensured that if leave broke down, patients could return to the wards immediately.
- Patients did on occasion move between Amber and Jade wards, however this was on clinical grounds such as safeguarding concerns, for example, if two patients on the same ward were a risk to each other.
- Discharging planning was evident, and delays only occurred for clinical reasons. Staff and patients would plan in advance discharges to home, other hospitals, and residential community setting. Planning would take place during patient weekly reviews, which would include a variety of different professionals, alongside parents, relatives, advocates, and patients. Consideration was given to patients' individual needs, for example, if a patient was being transferred to another hospital this would be a graduated process and patients would be transferred at meals times as this helped patients to settle in. Those patients discharged to community settings would have gradual leave to their new placement. One patient that we spoke with had a photobook, with pictures of their new home. This included the front door, living areas, and outside spaces. The patient was proud of their photo book and we could see that they were looking forward to the move.
- Ward staff attempted to manage patients within the wards. By doing so, they considered the least restrictive environment in line with Mental Health Act code of practice. One patient had been placed on long-term segregation and was constantly supervised by four nurses. This was because of high levels of aggression. There was a segregation care plan in place, and a plan to support the patient to reintegrate with others. This had worked well for the patient, who with the support of the four nurses had been able to access community Section 17 leave to the cinema and other activities. We saw that appropriate care plans were in place to support the patient to access activities that enhanced their well-being and promoted recovery.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to male and female lounges and outside spaces. There were separate quiet areas for patients to see relatives in private and make telephone calls in private. On Jade and Amber wards each male and female bedroom area had one bedroom with a separate quiet lounge, equipped with a television and sofa. This was used to support patients who needed a quiet space away from other patients due to their individual needs. Staff gave examples of how this had supported patients with autism. When patients used these quiet areas, staff assessed the potential risks of them being isolated, and would carry out the appropriate level of observation required to ensure that patients' safety was monitored.
- The trust kept the garden areas neat, tidy, and well maintained. On Amber and Jade wards there was a variety of play equipment, including outdoor gym equipment, which was cleaned and checked for breakages regularly. There were three garden areas at Tuxford Avenue. One was neat and tidy with a variety of seating areas to provide a pleasant and relaxing environment. However, the trust had not kept the other garden areas as well maintained.
- Patients told us that they did not like the food available to them. Patients and relatives said the food was not good. One patient told us that they relied on their 'tuck box', which they were allowed to keep in their room, and which contained snacks of their choice. One patient said they wanted to buy their own food but patients were not allowed to store their food in the fridge. However, we found that on Amber ward patients had been able to put their own food in the fridge. We found that patients had choices of food and could have snacks and drinks throughout the day. Staff were aware of patient's views of food, as this had been discussed in communal meetings.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- Staff had considered the needs of the patient groups and had displayed easy to read picture menus. They also told us they were trying to improve the food, working with patients at the service at time of inspection. Patients had access to kitchen areas to prepare snacks and drinks under staff supervision.
- Patients were able to personalise their bedrooms. For example, patients could put posters on the bedroom walls and have pictures on display. They were able to bring in their own bedding. We saw that patients had their own music equipment, which had been tested to ensure the safety of the equipment. On Jade and Amber wards there were picture signs to help patients navigate around the ward areas which helped those who would found it difficult to read signs.
- Staff provided daily activities for patients. Each patient had an individual activity plans that staff discussed and agreed with them. These plans were included in their positive behaviour support plans. Occupational therapy staff would attend the ward to do different groups or work with individual patients. There were group activities off the ward in other areas of the hospital. Staff would also support Section 17 leave to attend activities outside the hospital such as going to the cinema. Staff told us that it was sometimes difficult to get patients to engage with activities and patients we spoke to told us they were often bored. Care records demonstrated that activities were taking place and that patients sometimes refused to engage.

Meeting the needs of all people who use the service

- All wards had good disabled access, including bathrooms, toilets, and bedroom areas. The outside spaces were accessible so that should a patient with physical disabilities be admitted they would be able to access the wards appropriately.
- Patients had access to a range of accessible, easy read information, displayed around the ward. This included accessible advocacy service information, weekly menu plans, and weekly activity plans. Activity plans included off ward activities and other activities that the occupational therapy team could offer across the hospital site. We saw that staff had picture references, for example to support patients who struggled to express their feelings verbally. This included pictures of faces expressing different emotions.
- Tuxford Avenue patients also had good access to easy read information that was accessible to patients. Patients attended educational classes during the day and we saw that these rooms were bright and furniture was well spaced out. Classrooms were well stocked with educational tools, and the classroom walls were decorated with a variety of educational posters.
- Staff communicated with patients well. The trust offered staff the opportunity to undertake autistic spectrum disorder (ASD) training diploma for young people. They also had made sensory integration training available to staff. This training was aimed at giving staff the skills to support patients with sensory integration impairment to organize, understand, and respond to the information they take in from their surroundings.
- The trust had not identified faith rooms. However, staff were expected to undertake equality and diversity training as part of staff mandatory training requirements. 96% of staff across all four wards had received this training. Staff told us that they considered patients religious, spiritual and gender needs, if these needs were identified within assessment. We did not see that any of these needs had been identified in the patient care files that we reviewed, and patients we spoke with did not have any concerns that these needs had not been met.
- The trust had a smoke free policy so staff did not allow patients to smoke within the hospital grounds. However they had considered the impact of such a ban on patients. On Amber and Jade ward patients could use disposable electronic cigarettes on a once only basis.

Listening to and learning from concerns and complaints

- Staff had displayed easy read information of how patients could make a complaint if they were unhappy about their treatment. We spoke with eight patients across the four wards and they all told us that they knew how to make a complaint. A relative told us that they had made a complaint about missing clothing. The staff had been very responsive and the clothing had been found. Measures had then been put in place which had successfully reduced clothing going missing.
- Staff told us that at Tuxford Avenue they carried out house meetings regularly with patients where patients could raise issues of complaint. We saw meeting minutes for these. Staff were aware of who each child felt comfortable to talk to and could support them to

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

raise concerns further should they wish too. The manager's office was always open and patients were able to talk to them at any time. Patients at Tuxford Avenue confirmed that these meetings took place.

- The wards reported that they did not have any formal complaints. However, it was acknowledged that complaints from patients and relatives were informally raised and dealt with quickly, and this was confirmed by patients and relatives. This had resulted in a lack of formally recording complaints, and monitoring outcomes and changes to practices.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- The trust had displayed vision and values posters on all ward areas so that patients could see what these were. Ward managers were able to tell inspectors about the visions and values of the trust and how these were reflected in everyday patient care.
- Staff told us that they talk about the trust's visions and values in yearly appraisals and link these to their yearly objectives. This meant that staff had a good understanding of how these values were implemented in their everyday work.
- Staff told us that senior managers at the trust had been known to visit the ward throughout the year. The chief executive held 'tea with the exec' sessions. These were drop in sessions when staff could go and talk about concerns they had. Staff told us that they felt able to approach senior trust staff if they wanted to express concerns or offer ideas for improvement.

Good governance

- Staff did not receive regular supervision in line with trust policy and procedures, with the exception of staff on Amber ward. All inpatient wards had high levels of qualified and unqualified staff vacancies, and regular staff filled these vacant shifts through the internal bank. However, due to the lack of supervision we could not be sure that management had considered the impact on staff in working increased hours in a pressured environment. This meant that staff might not have the appropriate support to ensure that care offered was at a high standard. Morale was particularly low on Jade ward, where they had experienced a high level of turnover in the preceding six-month period.
- However, most staff had yearly appraisals, a process where staff performance was monitored and training considered for the following year. Due to the lack of regular supervisions it was difficult to see how performance could be monitored regularly and effectively.
- All wards had sufficient amounts of staff to care for patients safely, because regular staff filled the vacant shifts. We looked at staffing rotas and there were always enough qualified staff on duty. When additional staff were needed to support patients on higher observation levels, or support patients to access their Section 17 leave, we saw that managers would increase staffing levels.
- During inspection we saw that there was sufficient staff available to interact with patients on the ward and to facilitate off ward activities. The nurse in charge clearly outlined staffs' responsibilities for each shift, including allocating staff to patients, for whom they would be responsible. Qualified staff responsibilities included clinical audits such monitoring care plans and risk assessments monthly, and medication (MARS) weekly audited to ensure that errors could be identified. These audits would be reviewed by the manager. Audits took place at night so that day staff were freed up to interact with patients.
- Staff participated in clinical audits. Staff completed audits on care plans, risk assessments medication, and environmental health and safety audits. We reviewed these audits and found that they were being completed on a monthly basis. Any issues highlighted were fed back to the managers and discussed in the multi-disciplinary team meeting. These were also discussed in the senior management meetings. We reviewed the minutes of these meeting and saw that issues had been discussed and action taken to make necessary changes and any risks were put onto the trust risk register.
- There was an effective incident reporting system and learning from incidents was evident.
- Ward managers told us they had specific targets to gauge the performance of the team. However, mandatory training across the wards was below the trust's target. This included safeguarding, Mental Health Act and Mental Capacity Act training. We did not see how the trust had taken measures to ensure that staff received the appropriate training when they needed it. Managers would feedback to integrated performance committee, including the chief executive, who would review how teams were performing and agree actions that would be taken to address issues.
- The four wards had used high levels of restraint over a six-month period. On Amber ward, 122 restraints out of 265 were in the prone position. The trust had recognised at board level the high use of restraint, but had not successfully implemented recommendations identified in 2014, and reviewed in 2015, to manage and minimise the use of prone restraint in line with national guidance. This included recommendations of medical reviews

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

following any restraint as stipulated in the trust restraint policy. We did not find evidence that the use of all prone restraints was justifiable on the grounds of 'exceptional circumstances'.

- Each ward manager had administration support in the form of a ward clerk. All ward managers told us that they felt they had sufficient authority to make decisions based on staffing and patient need. For example, increasing staff levels to safely cover the needs of the ward. The ward manager would highlight issues of concern which were updated on the trust risk register. Staff could contribute to this through the ward manager and felt able to raise risk concerns.

Leadership, morale and staff engagement

- Jade ward had higher than the trust average sickness rates at 7.6% between December 2014 and November 2015. The trust's target was 4.6%. Staff morale on this ward was low due to high staff turnover. Tuxford Avenue's sickness rate for the same period was 6% and Amber ward 3.5%. Morale on both these wards was good.
- No bullying and harassment cases were recorded but staff told us that managers were approachable if they had any problems. Staff told us that they understood the whistleblowing process, and felt they could raise concerns without victimisation. With exception of Jade ward, staff morale was high and staff gained a sense of satisfaction in their roles. Staff worked well together within their individual teams, but this mutual support was not transferable across to other wards. For example, Amber and Jade ward admitted patients with similar needs, but they did not work together to the benefit of each ward and we fed this back to the management team.
- Staff were giving opportunities to expand their knowledge and develop their roles. For example ward managers could access a week's leadership and management course. Unqualified staff were supported to undertake a national vocational qualification level 3, which could lead to a secondment to complete a foundation degree, followed by undertaking a nursing degree. One ward manager had successfully been through this secondment process, starting work as a health care assistant.
- Staff acknowledged errors and reported these appropriately through the incident reporting systems in place. The ward manager of each ward reviewed and investigated these and reported to the senior management team. When errors happened staff would alert the appropriate people. For example, if a medication error was made staff would report this to the doctor and pharmacist as well as to the patient and next of kin.
- Ward managers held weekly formulation meetings. During these meetings staff could discuss individual patient needs and how to improve support for individuals. This empowered staff to feedback on the service they provided and drive up standards of care.

Commitment to quality improvement and innovation

- The trust told us that they were involved with NHS England transforming care for people with learning disabilities. This scheme was aimed at empowering patients and their families, and ensuring that patients get the right care at the right time. A clear admission and discharge policy supported patients to receive the right care at the right time.
- In some cases staff had been innovative in supporting patients through the process of discharge. For example, creating a photo folder of a patients new home, and reviewing this and talking to them for some weeks before to help them to get use to the idea of moving.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met:** Staff on the adolescent wards had limited understanding of capacity and consent, in particular for adolescents under the age of 16. Training across all wards was poor, 52% of staff on Jade had received appropriate training in the Mental Health Act and Mental Capacity Act. This training was not mandatory for unqualified staff. **This was a breach of Regulation 11 (1) (2) (a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Bathroom areas at Tuxford Avenue had potential ligature points that had not been identified, mitigated or addressed. These were areas which patients used unsupervised. **This was a breach in Regulation 12 (1) (2) (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** The four wards used high amounts of restraint over a six month period. On Amber ward, 122 restraints out of 265 were in the prone position. The trust had recognised at board level the high use of restraint, but had not

This section is primarily information for the provider

Requirement notices

successfully implemented recommendations identified in 2014, and reviewed in 2015, to manage and minimise the use of prone restraint in line with national guidance. This included recommendations of medical reviews following any restraint as stipulated in the trust restraint policy. We did not find evidence that the use of all prone restraints was justifiable on the grounds of 'exceptional circumstances'.

This was a breach in Regulation 13 (4) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** Staff were not receiving regular supervision in line with trust policy. This meant that staff were not being monitored to make sure competence is maintained. There was a high number of staff vacancies across the service. Tuxford Avenue had over 50% vacancies. It was not clear how the trust were going to recruit into these vacancies. **This was a breach in Regulation 18 (1)(2) (a)**