Requires improvement

2gether NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Date of inspection visit: 26-30 Oct 2015
Date of publication: 27/01/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RTQ54	Hollybrook	Hollybrook unit	GL5 4SA
RTQ05	Westridge	Westridge assessment and treatment service	GL10 3HA

This report describes our judgement of the quality of care provided within this core service by 2gether NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by 2gether NHS Foundation Trust and these are brought together to inform our overall judgement of 2gether NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
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 trust had been working with Gloucestershire clinical commissioning group and Gloucestershire county council to agree and develop a new model of care for patients with learning disabilities for some considerable time. Whilst there was a commitment by all to provide high quality services close to home for patients with complex needs and some redevelopment work has started at Hollybrook there had been several setbacks with the plans to develop a community supported living facility
- there was no clear discharge process for patients and those with discharge plans had no timeframe for discharge
- at Hollybrook all patients had been in service since 2012 and one had been there for 17 years
- there were no effective processes in place for patients to input into their care or the development of the service. The were no plans to address this and no plans to involve patients in planning the new service
- we were concerned there may had been episodes of seclusion that were not recognised or recorded as such by staff. Staff had not always followed the trust policy on seclusion
- the unit was not using outcome measure tools to assess and monitor patient progress
- staff continued to use china cups on a ward even though the patient were not allowed to use these and had to use plastic cups
- staff at Westridge wore a uniform that consisted of a blue tunic and blue trousers, which resembled a theatre uniform. Staff told us that at least one patient's family felt the uniform was inappropriate. There were no plans to review the style of uniform worn
- patients did not receive a copy of their care plan and patient's views were not recorded in their care plan. In Hollybrook staff felt patients would not understand their care plan and no attempts had been made to address this issue
- the reasons why patients might lack capacity was not reviewed regularly
- the trust's covert medication policy was not always followed
- the patient satisfaction tool in place was not accessible by patients with poor literacy skills. most patients were unable to use the complaints procedure. There were no plans to address this
- at Hollybrook staff had not had formal supervision although reported that informal supervision took place and that they felt supported

However:

- as part of the new model of care the trust had developed a learning disabilities intensive support team to support patients that would normally be admitted to hospital to be cared at home. This had resulted in fewer admissions to the inpatient units
- the units were clean and tidy and furnishing was in a good state of repair
- prone restraint (when a patient is held lying face down on the floor) was never used on Hollybrook and only used in Westridge when a patient had taken themselves to the floor, face down and was then only used for the shortest time necessary
- staff were trained in proactive behaviour management techniques. Behaviour management plans were individualised and based on the analysis of incidents. Staff could explain the types of behaviours patients displayed and a range of interventions used
- all patients had risk assessments on admission and a care plan for any identified risk
- care plans were in place and were reviewed regularly and records were kept securely
- staff received safeguarding training and could advise us on how to respond to a safeguarding issue
- a number of items were restricted on both sites this included alcohol, knifes and other dangerous items which was appropriate to the services, additional restricted items were based on the individual patients need
- physical health was assessed on admission and necessary on going health monitoring was in place
- we saw patients being treated in a compassionate way and treated with dignity and respect
- communication aids were used that were personalised and met patients' needs. For example, a DVD had been developed to advise patient about admission to Hollybrook

Summary of findings

- family contact was encouraged and patient could use a variety of methods to remain in contact
- patients could personalise their room
- the service considered patient compatibility when considering admissions

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 could not demonstrate a clear understanding of seclusion. We were concerned that episodes of seclusion had occurred that had not been recognised or recorded as such and staff did not always followed the trust policy on seclusion.
- Two of the bungalows at Hollybrook had seclusion rooms. Staff were unable to communicate with patients in seclusion. There were no toilet facilities for patients in these facilities and no beds or mattresses.
- Care plans around the use of the seclusion room for non-seclusion activities did not make it clear that patients could leave the room when they chose to.

However:

- Both units were clean, tidy and furnishings were in a good state of repair. There where alcohol gel dispensers at the entrance to clinical area and we observed staff using them before.
- There was a central register of medical equipment used to ensure calibration and maintenance occurred at the correct time.
- Bags containing resuscitation equipment were sealed and we saw records to show that equipment checks occurred weekly and the seal checked on a daily basis. These checks were up to date. Both units conducted six monthly medical emergency scenario tests.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Mediation was given covertly on occasions and staff did not follow the trust policy.
- We did not see any detailed information recorded in the care plans as to why the patients' lacked capacity.
- Some members of staff did not feel part of the multidisciplinary team and felt suggestions were not listened to when made more junior staff.

However:

- We saw evidence that patients had a physical health assessment on admission. Where necessary ongoing physical health monitoring care plans were in place.

Summary of findings

- Care plans were up to date and reviewed regularly. They addressed patients' identified needs.
- The wards had access to a range of professional staff, such as a consultant psychiatrist, speech and language therapist, psychologist, nurses, an occupational therapist, pharmacists, a music therapist and advocacy services.
- Safeguarding plans were recorded on RiO (the electronic patient record system used by the trust) and discussed at handover meetings. There were three handovers a day between each shift, attended by all oncoming staff, and the nurse from the previous shift. Handovers also included staff training and team meetings.
- We saw care plans that indicated people's rights under the Mental Health Act were explained to them every two to three weeks and that this information was available in an easy read format.

Are services caring?

Good

We rated caring as good because:

- We observed patients being treated in a compassionate way with respect for their dignity
- Families were encouraged to visit regularly. Where this was not possible, staff contacted family members via the telephone to update them on their relation's progress. Patients were also able to speak with relatives using tablets and laptops. Staff felt they had good relationships with patients' families as did the advocate, and this was confirmed by the carer we spoke to. We observed staff ensuring a family member could attend a care programme approach meeting, by ensuring it was at an appropriate time and arranging transport.
- New patients were able to visit the units prior to admission. Hollybrook had developed a DVD that gave advice on what would happen during the patients stay.
- Staff used adaptive communication to explain treatment.
- Patient compatibility was considered during the assessment for admission process.

However:

- Patients did not receive a copy of their care plans and there was no record kept of their opinion of their care.
- Staff informed us that families had commented that the uniform looked inappropriate but there were no plans to review it.
- Restricted items (china cups) were used by the staff in front of the patient.

Summary of findings

- The patient survey in place was not suitable for the patient group, as it did not make any adjustments for their communication needs. However, the trust responded immediately that this was drawn to its attention and has made arrangements to ensure patients are supported to complete the survey.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because: (needs some amends)

- The trust had been working with Gloucestershire clinical commissioning group and Gloucestershire county council to agree and develop a new model of care for patients with learning disabilities for some considerable time. Whilst there was a commitment by all to provide high quality services close to home forpatients with complexneeds and some redevelopment work has started at Hollybrook there had been several setbacks with the plans to develop a community supported living facility
- Hollybrook had not discharged any patients since 2012 and some patients had been resident for 17 years. The service redesign was taking place specifically to ensure this would never happen in the future.
- Staff were unable to identify any learning from complaints
- At the time of the inspection there were no arrangements in place to support patients who wished to complain. The trust responded immediately when we raised this and put appropriate arrangements in place

However:

- Staff developed information about medical procedures in an accessible format to support a patient attending general hospital.
- Patients were able to personalise their bedrooms and the communal areas of the wards if they wanted to.
- Patients had a variety of activities seven days a week including cooking, painting, computer and board games, trips to the local area, the seaside and safari parks.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a service review underway and there was number of significant changes to the management of Hollybrook. This has impacted negatively on staff morale.

Summary of findings

- There was not an effective system in place to ensure supervision was provided in line with the trust policy
- Reviews of care plans had not identified a lack of patient involvement or issues around the use of seclusion rooms and covert administration of medication

However:

- Staff we spoke with said they felt supported by the manager.
- The teams always had adequate levels of staff levels on duty.
- Staff felt comfortable about raising concerns.
- Staff were able to provide input about the development of the service.

Summary of findings

Information about the service

Information about the service

Hollybrook is a rehabilitation and treatment unit, which provides inpatient services for up to eight male and female patients with a learning disability. It is divided into four two bedroom bungalows all contained in one building. It has a separate administration building and a refurbished bungalow on site that was not in use. At the time of our inspection there were four patients on the unit. They had all been resident in Hollybrook since December 2012 and their length of stay varied from three to 17 years.

Westridge is an assessment and treatment service, which provides inpatient care for up to eight patients with a learning disability and complex needs. It consists of two wards of four beds connected by an office. At the time of our visit there were two inpatients.

The learning disability inpatient service was due to go through a redesign; Westridge is due to close once the two patients have been discharge. Two of the patients admitted in Hollybrook will be transferred to the refurbished bungalow and the other two patients are due to be moved to Westridge while Hollybrook is refurbished and then moved back.

Service redesign

The trust had been working with Gloucestershire clinical commissioning group and Gloucestershire county council to agree and develop a new model of care for patients with learning disabilities for some considerable time. The strategy is to proved a range of health and social care support, including, inpatient services, intensive support services to help patients stay in their own home (normal place of residence) when in crisis and community supported living placements.

The trust and commissioners have been attempting to commission a community supported living from a variety of skilled third party providers.

The redesign of services involves the refurbishment of the Hollybrook buildings to provide for four individual placement units which are being built in the style of individual self-supported living accommodation.

Whilst there was a commitment by all to provide high quality services close to home for patients with complex needs and some redevelopment work has started at Hollybrook there had been several setbacks with the plans to develop a community supported living facility.

Our inspection team

The overall inspection was led by:

Chair: Vanessa Ford, director of nursing standards and governance, West London NHS trust

Head of Inspection: Karen Bennett-Wilson, Care Quality Commission

The team that led the inspection of the wards for people with learning disabilities or autism comprised of one inspector, one psychologist, a Mental Health Act (MHA) reviewer, a senior nurse and a retired manager of learning disability services.

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 provider:

- 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 we already held about the trust such as the results of previous inspections. We asked the trust to provide information about incidents, safeguarding alerts, staffing issues, and admission and discharge information. We sought feedback from carers by holding listening events.

During the inspection visit, the inspection team:

- visited both Hollybrook and Westridge inpatient units
- spoke to three of the six the patients currently admitted, unfortunately they were unable to discuss the care provided
- spoke to 10 staff members
- spoke with one carer
- spoke with the advocate who visits the service
- attended a multidisciplinary meeting
- reviewed five sets of patients records
- reviewed a range of documents and policies

What people who use the provider's services say

We were able to speak to three patients while we were on site. However, they were unable due to communication issues to share their experiences with us. One patient who could share their opinion with us declined to speak with the inspection team.

We were able to speak with one carer by telephone. The carer told us that it was the best place for their relative and they were happy there, that staff team always kept them advised of any changes in their relatives care and involved families in the care planning process. The staff team are experts at looking after their relative and their admission to unit had a dramatic, positive effect on them.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure staff fully understand the policies and procedures relating to seclusion and patients have a robust care plan in place for using the seclusion room and are aware of their rights. Up to date and accurate records must be kept when using the seclusion room for non-seclusion purposes.
- The trust must ensure patients have copies of their care plans in a format they can understand.
- The trust must ensure it keeps a record of why the patient does not have a copy of their care plan.
- The trust must ensure it review patient's ability to consent and all appropriate people are included in review meetings.
- The trust must ensure all covert medication is given in accordance with trust policy.

Action the provider SHOULD take to improve

- The trust should ensure that all equipment in the clinic rooms is in date and replaced when necessary.
- The trust should ensure it records the reason for the cancellation of leave.
- The trust should ensure the uniform is appropriate to the patient group whilst also meeting the needs of the staff.

Summary of findings

- The trust should ensure the complaints procedure is suitable for the patient group.
- The trust should ensure the supervision policy is consistently applied.

The trust should ensure there is suitable management cover at Hollybrook.

2gether NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hollybrook unit	Hollybrook
Westridge assessment and treatment service	Westridge

Mental Health Act responsibilities

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

- At Hollybrook, one patient's treatment was under the authority of T3 form. A T3 form is completed by a second opinion appointed doctor if they are in agreement with the proposed treatment. T3 forms are used when a patient is refusing treatment or lacks capacity to consent to their treatment. A patient at Hollybrook was receiving medication in food and drink. They had a care plan stating that the patient had agreed to this. However, their consent to treatment mental capacity assessment stated that they lacked capacity. The unit was not following the trust's covert medication policy. There was no evidence, in the patient file, that a best interest assessment to agree the use of covert medication had taken place.
- The patients had access to an advocate, who visited the ward regularly.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There was not a consistent approach to Mental Capacity Act (MCA) training. One member of staff said they had received training and it was very good. Staff told us there was no refresher training and MCA training only occurred on induction. A staff member told us there was no direct training in the MCA but has had some due to being on a NVQ level three health care course.

Detailed findings

- Of the five patient records, we reviewed, best interest decisions were documented but there was no documentation of the discussion as to why the patient lacked capacity to make decisions relating to their care.
- At the multidisciplinary team meeting, that we attended, staff made assumptions that patients did not want to see their care plans. Staff told us and we saw that there was a policy on the MCA to help safeguard people's rights.

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

- Hollybrook ward comprised four interconnected two-bedroom bungalows with a separate administration block. Westridge had two four-bedroom wards. A single office allowed staff to view and access both wards. All of the patient areas had their own outdoor space for the exclusive use of the patent admitted to that area.
- Both units were clean, tidy and furnishings were in a good state of repair. Alcohol gel dispensers were at the entry of each ward. We observed staff using the gel before entering the clinical areas. Medical devices, blood pressure machines and defibrillator, were clean and well maintained. There was a central register of medical equipment used to ensure calibration and maintenance occurred at the correct time. We saw cleaning records that were up to date.
- We saw a ligature assessment for both units, completed in July 2015. There were no ligature concerns identified in Hollybrook. This was confirmed during our visit. Westridge had identified some ligature risks in the general ward areas and these were managed by the presence of staff. Staff were present in the patient areas at all times and ligature cutters were available with all resuscitation bags. The units had defibrillators available on both sites. Resuscitation bags were sealed and we saw records to show that the equipment was checked weekly and the seal checked on a daily basis. These checks were up to date. Both units conducted six monthly medical emergency scenario tests with the assistance of other members of the trust. The resuscitation bag on Westridge was in the office behind the office door. This was not visible as the door was propped open. The resuscitation bags on Hollybrook were behind locked doors that did not have any signage to indicate they were there.
- Although there were three clinic rooms, physical examinations of patients occurred on the ward or in their bedrooms. Some wound cleaning wipes and wound dressings kept in the clinic rooms were out of date; staff replaced them during our visit.
- Two of the bungalows on Hollybrook and both wards on Westridge had seclusion rooms, which did not have a system in place to allow staff and a secluded patient to communicate. There were no facilities to allow secluded patients access to the toilet. There was no mattress or beds within the seclusion facilities. Patient's observations were made via CCTV from outside the seclusion room.

Safe staffing

Hollybrook current staffing:

- Three qualified and five unqualified nurses on a day shift.
- One qualified and five unqualified nurses on a night shit.
- Two fulltime qualified nursing vacancies
- Eleven fulltime unqualified nursing vacancies
- Five shifts a week were covered with block booked unqualified agency staff. The trust reported that Hollybrook was using over 30 shifts of bank or agency staff a week.
- One member of staff was on long term sick.
- Six staff had left in the past year and six retirements were due.
- Recruitment was underway for two qualified nurses and 11 unqualified nursing posts.

Westridge current staffing:

- Two qualified and three unqualified nurses on each day shift.
- One qualified and two unqualified nursing staff on a night shift.
- Two full time qualified nurse vacancies.
- Recruitment was under way for ten health care assistant, four permanent and six temporary staff.
- Each day agency staff covered one to two shifts, usually nights and by staff that were known to the team.
- Sickness levels were at 3 % for the last 12 months which was below the trust's and the national average.
- Six staff had left in the past year.
- Staff reported that there was usually enough staff to meet patients' needs and ensure both patient and staff safely. Escorted leave would usually only be cancelled due to the patients behaviour and rarely due to staff shortages.

Requires improvement

Are services safe?

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

- Staff were able to work additional hours to cover shifts, where needed. Each patient, across the two services, always had a member of staff assigned to work directly with them and more assigned if required.
- There was enough appropriately trained staff on each unit to manage any aggressive and challenging behaviour safely. There were reflective practice meetings weekly, on a Friday, but staff would have liked more, particularly after incidents of restraint. Only one member of staff was not up to date with positive behaviour management training; the trust system for dealing with aggressive and violent behaviour. Trust policy stipulated that staff could not work directly with patients until this training was completed. Twelve out of thirty-four staff would require refresher training in the next two months.
- Eight eight percent of the units staff were up to date with the required mandatory training that included health and safety, fire, moving and handling and food hygiene. Staff received additional informal training in pictorial/symbol communication and the use of social stories, a technique used to improve people's understanding of social rules with people who have learning disabilities, from the speech and language therapist. All staff completed online autism training and three members of staff were completing an NVQ level three in health care. The wards also provided additional training to agency staff, to ensure they had the skills needed to work with this complex patient group.

Assessing and managing risk to patients and staff

- We were concerned there may have been episodes of seclusion that were not recognised or recorded as such by staff. Both patients who were living on bungalows (Hollybrook) with seclusion facilities used the seclusion rooms at their own request, without the door closed. Staff reported that on some occasions both patients wanted the door closed. We looked at the care plans in relation to this and identified that staff instigated that the patient should go to the seclusion room and the patient was advised that they would be taken if they did not go themselves, physical interventions could be used to take the patient to the seclusion room. Therefore, the patient would not be voluntarily using the seclusion room. There was no limit to how often patients were told to use seclusion room. The care plans of both patients identified staff instructing the patient to "sit down" and that they could leave once they were "calm". Staff told us that they would not prevent the patient leaving the seclusion room, but this was not clear in the three care plans we reviewed. Staff advised us that the patient knew they could leave when they wanted to despite the care plan advising the patient they had to stay in the room until they were calm. There was no assessment of how the team knew that the patients were aware they could leave if they wished to. There was no assessment of patient capacity recorded in the care plans. In the patient views section it indicated, that neither patient could contribute to their care plan as they lacked capacity, and staff advised us that the use of seclusion with both patients was historic and that the patients found it supportive. There was no recording log in the patient records of how often `non-seclusion` in the seclusion room took place, how often the door was shut or how long the patient remained in the seclusion room. Staff also told that use of the seclusion rooms for a non-seclusion purpose not recorded or audited formally. This meant we were not able to assess or confirm the frequency or specific nature of its use.
- Both wards used a derogation of seclusion policy when secluding a patient. These were in place for two patients, as neither ward had a doctor on site 24 hours a day. This policy allowed the units to deviate from the trust's seclusion policy and the Mental Health Act code of practice as there could be a delay in the doctor being able to visit the site. Staff were unable to advise us at what point they should follow the trust policy. One of the nine seclusion records we reviewed had exceeded the agreed period of 30 minutes, without reverting to the trust seclusion policy. Staff should have informed the on call doctor that seclusion was happening. However, the doctor was not called, in three records we reviewed, until after seclusion had ended. In a trust audit of seclusion, undertaken in August 2015, Hollybrook and Westridge achieved 98% compliance to the trusts seclusion standards. However, we identified two additional seclusion records that had not been included in the audit. It was reported that this was due to three records that had been loaded as a single file onto the electronic records system, which was not identified by the person completing the audit.
- Staff reported that physical restraint occurred at least daily with two patients on Hollybrook, and less often with the other patients on the ward. This tended to be seated restraint. Supine restraint, when a patient is held on the floor face up, occurred about three times a week.

Requires improvement

Are services safe?

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

All physical interventions were recorded on a positive behaviour management monitoring form, the system used by the trust to manage aggressive behaviour. If a non-standard positive behaviour management hold was used, the form was also sent to the lead trainer, for review. Non-standard holds were mainly used in relation to helping patients with personal care activities. Two staff on Hollybrook reported that prone restraint was never used, only supine, and only as a last resort. Prone restraint had occurred, on one patient on Westridge seven times in the past 12 months. Staff informed us this was because the patient dropped to the floor, during an incident, on to their front. The staff team facilitated a supine position as soon as they could.

- Staff received proactive intervention training as part of the positive behaviour management training, which covered identifying different types of behaviour. The multidisciplinary team analysed behaviour issues and devised the behaviour management plans, which were different for each patient. Staff reported that they would always use de-escalation techniques with patients, such as verbal redirection and a low stimulation approach, prior to using physical interventions.
- Staff stated that the units were not currently using positive behaviour support, a management system used to understand what maintains an individual's behaviour, as they were still waiting for training. However, we saw care plans that identified proactive and reactive behaviour management strategies. Staff were able to explain the type of behaviours that patients displayed. They would intervene using agreed interventions such as distraction and weighted blankets, a therapeutic technique where adapted blankets apply pressure that provides comfort and relaxation.
- All patients had a risk assessment on admission. We observed risk assessments that were comprehensive and provided a care plan on how to minimise identified risks. Patients had a risk summary on RiO, which was updated weekly. Staff used the RiO risk assessment tool. Staff reported being able to access risk assessments when required. One member of staff we interviewed said that they could not always access RiO, as there were not computers on every bungalow. However, we observed paper files, were there were no computers, that included relevant information about the patient, care plans and risk assessments.
- We were told that staff received safeguarding training on induction. Health care support workers we spoke with described how they would report any safeguarding concerns to the nurse in charge who would take appropriate action. Staff advised us that they would complete a datix incident form for any incident and would complete a body map, a diagram of a person used to indicate the location of injuries, if a patient had any identified marks or injuries. Safeguarding information, including individual patient protection plans, were recorded securely on the electronic record system and shared with the whole staff team during handover.
- Staff were able to explain different observation levels, for example, checks being carried out at 15 minutes and hourly intervals. Staff maintained patient safety at all times and would undertake searches on admission to the ward.
- Medication was stored securely and in appropriate cupboards on each site. There was medicine refrigerators in place, temperatures were recorded daily and were within the safe range. There was no monitoring of the clinic room temperature. On the 27 of October 2015 during a pharmacy inspection, it was noted that emergency medication for the use in anaphylaxis was out of date from 30/09/2015 staff reported that it was a pharmacy role to check this but the head pharmacist felt it was a nursing role. The wards used a comprehensive prescription and medicines administration record chart that facilitated the safe prescribing and administration of medicines. We saw that there was regular review of patients' prescriptions. Staff had completed administration records to confirm patients were receiving their medicines as prescribed. There was an appropriate system in place to monitor and record medication errors. It was not recorded that a pharmacist had been consulted around the given of medication in food and drink, and it was noted that the care plan around this did not cover all methods that staff were covertly giving medication. When medication was given in a drink, staff recorded as taken even if the patient only drank a small amount, which could affect the monitoring of the medications effectiveness. When patients were prescribed medicines to be given 'when required', care plans were in place to support nurses to give these medicines safely and consistently.

Track record on safety

- There had been no serious incidents reported in the past 12 months.

Requires improvement

Are services safe?

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

Reporting incidents and learning from when things go wrong

- Staff at Westridge told us about the type of incidents they would report and were able to explain how information shared about lessons learnt following incident, got shared via handovers, team meetings and emails.
- Datix was used for recording and reporting incidents. All staff had access to the datix incident recording system. Staff were encouraged to record every incident including physical interventions, self-harm, slips trips and falls and staffing levels. The deputy manager advised that it was a high reporting service with the most datix being submitted in the trust. Staff were able to identify lessons learnt from incidents elsewhere in the trust such as; the units ensured that the oncoming shifts qualified nurse had seen all patients at the start of their shift.
- In addition, a positive behaviour management form recorded physical interventions. Following a supine restraint (when a person is on their back) staff were always given a debrief. It was the responsibility of the staff members involved to complete datix for each incident. The positive behaviour management team, a group of staff with additional training in the use of physical interventions, reviewed the incidents and gave feedback on what went well, what did not and any lessons learnt from elsewhere in the trust. The local positive behaviour management team had training days five times a year, which they used to review incident reports.

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

- We saw evidence that patients had a physical health assessment on admission. Where necessary ongoing physical health monitoring care plans were in place. Patients had physical observations taken every week and recorded on the electronic patient record, such as blood pressure and weight. Every three months staff returned the essence of care audit, a Department of Health framework designed to encourage best practice and ensure the meeting of physical health needs for patients in hospitals dealing with mental health issues. There were good contacts with the local G.P who visited or contacted the ward weekly and when required. A dentist visited the unit every six months, or sooner if require. There were comprehensive assessments of patients' needs associated with their learning disability, linked to care plans. Care plans included meeting patients' behavioural needs that identified appropriate proactive and reactive interventions.
- RiO kept all patient records secure. Paper records were locked in a cupboard. All staff had access to RIO and were able to access the information they required. Another member of staff we interviewed said computers were not available in all the ward areas. However, paper backup files were available in the locked cupboard on the ward.

Best practice in treatment and care

- Staff interviewed told us that psychology support was available but it was not always scheduled. Psychology support was not available to one patient, as the patient had refused to meet the psychologist. However, they offered support to the staff team with coping strategies for the staff working with the patient and advice on the care provided. A psychology assistant worked across the inpatient service and the learning disability intensive support service (LDISS) and this provided some continuity for patients.
- Senior staff completed audits in relation to handwashing, medication missed doses, the safety thermometer, a malnutrition screening tool (MUST) and seclusion.
- The service no longer used outcome measures to evaluate the patients' outcomes. They had used health of the nation outcome scales but this had stopped when the trust started to use the health equality framework, this tool was not available to the learning disabilities inpatient service.

Skilled staff to deliver care

- Staff could request to go on specialised training and the manager would try to arrange this. Staff were able to access on line autism training. Staff on the units had previously received communication training and told us this needed to be refreshed; this would be taking place soon due to the appointment of a new speech and language therapist. Staff received an email to advise them of upcoming relevant training courses.
- The manager had not had to use the performance management policy, but said that he was aware of the policy and would be able to get support from the human resources team.
- The trust's supervision policy is for staff to have ten formal supervisions within a twelve month period. We looked at nine supervision records on Hollybrook and none had received the required amount within the last twelve months. Eight out of nine had not had any formal recorded supervision in 2015. There were weekly reflective practice meetings and a de-brief was always offered following an incident. All staff we spoke to told us they received informal supervision, by talking with their colleagues, which was not recorded.

Multi-disciplinary and inter-agency team work

- There were weekly multi-disciplinary team (MDT) meetings attended by all members of the MDT. Some staff we spoke with did not think that the MDT worked as effectively as it could, or listened to ward staff's feedback. For example, new ideas and suggestions about activities were not acted on. The advocate advised us that they felt listened to and their opinion counted when given. We attended an MDT meeting and observed that the team followed a set agenda and all team members had an opportunity to speak.
- Staff reported good links with patients' social workers and commissioners and they attended meetings when invited.

Adherence to the MHA and the MHA Code of Practice

- Staff demonstrated an understanding of the Mental Health Act and would request training if required.

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.

- At Hollybrook, one patient's treatment was under the authority of T3 form. A T3 form is completed by a second opinion appointed doctor if they are in agreement with the proposed treatment. T3 forms must be used when a patient is refusing treatment or lacks capacity to consent to their treatment. The patient at Hollybrook was receiving medication in food and drink. The care plan stated the patient had agreed to this. However, the consent to treatment mental capacity assessment recorded stated they lacked capacity. The unit was not following the trust's covert medication policy. There was a best interest assessment and that had identified that the patient lacked capacity.
- An advocate visited the service regularly. The Independent Mental Health Advocate (IMHA) reported a good working relationship with ward staff. People received information about the IMHA on admission and staff knew they visited the ward regularly.

Good practice in applying the MCA

- One patient was currently subject to a Deprivation of Liberty Safeguard under the Mental Capacity Act in Westridge. We identified that the local authority had approved this.
- Best interest decisions were documented in the five care records we reviewed but there was no documentation of the discussion as to why the patient lacked capacity to make those decisions. At the MDT meeting we attended, staff agreed patients lacked capacity but did not discuss why or in what areas they lacked capacity. Staff made assumptions that patients did not want to see care plans and did not want to meet with them as they had previously refused; one member of the team discussed how they planned to continue attempting to engage with the patient. Staff told us there was a policy on the Mental Capacity Act to help safeguard people's rights; we reviewed this policy and felt it was appropriate.
- Staff do not give patients on Hollybrook a copy of their care plans and there was no record kept of their opinion. The patient view section of each care plan only identified that the patient did not have capacity. We did not see any information recorded in the care plans as to why the patient lacked capacity
- Staff reported that none of the patients as able to advocate for themselves. We did not see in care plans or at the multidisciplinary team meeting any evidence of staff reviewing decisions about capacity or discussing the level of choice a patient could manage.

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 expressed compassion and care towards patients. We observed staff interacting with patients in a compassionate manner. Staff were able to give us examples of how they tried to maintain dignity during physical interventions. The advocate stated that the staff team had a very good relationship with patients.
- At Hollybrook, one patient was not allowed to use china cups due to the risk of self-injury, but staff still used china cups in front of this patient. We felt this did not respect the dignity of the patient as it identified them as being different to the staff.
- At Westridge, the staff team wore a uniform that consisted of a blue tunic and blue trousers, over their own clothes, which had the appearance of a theatre uniform and did not suit the care environment. This was used to manage an infection control issue, as staff often had to deal with bodily fluids, but was always worn when staff were on duty other than in the community. Staff told us, that family members had commented that the uniform looked inappropriate.

The involvement of people in the care they receive

- Staff stated that patients were as involved as possible in their treatment and care planning. At Westridge, they had a patients meeting where the patients were encouraged to plan an agenda and participate in the meeting. However, only one patient attended as the other patient chose not to.
- No current patients were able to complete a satisfaction survey, as it was not in a format that they could use. The speech and language therapist would assess new patients to see if they were able to complete the patient satisfaction survey.
- New patients would be able to visit the unit prior to admission. Patients received an induction pack that explained their treatment, care plans and rights. Hollybrook had developed a DVD which was given to the patient and their carers prior to admission. The DVD gave advice on what would happen during their stay in Hollybrook.
- The units used easy read information and staff gave examples of how they had used adaptive communication to support a patient to access a general hospital by developing information about the procedure they would be having.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- At Hollybrook there was a total of four inpatients and at Westridge there was a total of two. The units would still admit patients but consideration was given to the patient mix when reviewing referrals to the units. Staff reported that this was to ensure existing patients' care was not affected by a new patient and not because they could not meet the needs of referrals. One patient was out of area despite being suitable for the service. This was because they were not considered compatible with the existing patients.
- Neither unit was operating at more than 50% capacity;
- All the patients at Hollybrook had been resident since 2012. One member of staff told us they had not seen anyone discharged in the eighteen months they had been working there. One patient at Hollybrook has been an inpatient for 17 years.
- The current service redesign plan was for Westridge to close following a refurbishment of Hollybrook and all learning disability inpatient services to be transferred there.
- Two of the patients in Hollybrook were transferring to a new bungalow on the Hollybrook site. There was some delay in this transfer occurring as they were awaiting final commissioning agreements. Staff advised us of the transition plan in place for this move.
- All the patients within the learning disabilities service had received a care and treatment review. This is a review to determine if a patient with a learning disability needs to remain in hospital or could receive appropriate treatment in the community. Both patients in Westridge no longer needed hospital treatment and should be discharged. We were advised that an appropriate provider of supported living had been identified and a suitable property located but staff did not know when the patient would be move to this facility. However, there was no discharge plan in place for the patients. There was no agreed timeframe for discharge. We were advised that it was the commissioners of the service who were responsible for agreeing the discharge plans. We were advised that the social care provider had not begun recruiting staff and had recently decided that the patients should be discharged in to a supported living model rather than a nursing home model that had previously been agreed. Both patients' had a number of restrictive practices in place, such as limited access to the kitchen there were no plans in place to reduce these restrictions in preparation for discharge.
- Each patient has a care programme approach meeting and care co-originators and family members are invited to attend.

The facilities promote recovery, comfort and dignity and confidentiality

- The units used the cook chill system. Precooked meals were stored on site and heated when required. Patients did not give feedback on the quality of food as there was not a system in place they could use. Patients had the opportunity to cook for themselves and eat out. At Hollybrook there was a small kitchenette in each flat where patients could make drinks and prepare snacks. Individual restrictions may apply to this based on the patients' needs. One carer advised that they felt their relative enjoyed the food.
- Patients were able to personalise their bedrooms and/or communal areas. One patient had put up newspaper cuttings, which a relative had sent.
- There were activities agreed with the patients. There were activities available on the units such as cooking, computer games, drawing, painting and board games. We also saw a trampoline on one unit which had just been introduced and the patient was not yet comfortable in using. Patients were also able to access trips in the community such as going for a drive, visiting the seaside and safari parks. Activities were available seven days a week. One patient at Westridge devised their own activity plan.

Meeting the needs of all people who use the service

- Each environment was adapted to meet the needs of the patients. We saw communication aids in place such as easy read information. Staff adapted how they communicated, to meet the needs of patients.
- They had tried different foods to meet a patient's preference and had altered the menus and ingredients accordingly.
- Both units were suitable for disabled access. They had wide doors and ample space and were all on the ground floor.

Listening to and learning from concerns and complaints

Are services responsive to people's needs?

Requires improvement

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

- Only one patient was able to use the complaint procedure, as it was not suitable for the patients. The patient that was able to complain would usually not want to make an official complaint once they had discussed the issue with the staff.
- Some families would complain on behalf of patients. One staff member advised us that there was no learning from complaints as the patient group was unable to complain. Staff were unable to identify any learning that had come from the complaints process.

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's values were displayed on each of the units. The units' goals were to support patients and to discharge to suitable placements, which fitted with the trust learning disability values. However, neither service were discharging patients in a timely manner.
- The deputy manager felt trust senior management was supportive of inpatient wards. The chief executive visited annually.

Good governance

- There was not an effective system in place, across both services, to ensure an effective supervision process.
- Three staff we spoke to confirmed they had received an appraisal. We checked nine appraisal records and eight out of nine had received an appraisal in past year. One member of staff had not received an appraisal since 2011.
- The manager was able to put items on the risk register if they needed to. At the time of the inspection, the only risk identified for the services related to staff vacancies. We were concerned that the reported high number of restraints and lack of progress around discharge were not included on the risk register so therefore not escalated to ensure senior management oversight.
- We identified that care plans and risk assessments were reviewed on a regular basis. However, this process had not identified issues around the use of seclusion and covert medication. We did not identify any peer reviewing or other quality checking processes in place.
- Staff reported that learning from incidents would be passed on via team meetings, emails and at handovers. However, they could not give any local examples to demonstrate this.
- The service had to complete commissioning for quality and innovation payments (CQUIN, quality targets set by NHS England that are linked to funding) on information governance and dementia which had been successfully completed.

Leadership, morale and staff engagement

- Staff felt confident about raising concerns, with either the manger or the deputy manager. One member of staff had raised a concern about clinical issues, and they felt supported during this process. Staff morale was good and staff told us that they enjoyed their role and it was a good place to work. It could be stressful but the teams were supportive.
- There was a service review underway and a number of changes to the units' management, which had caused uncertainty about the future of the services and model. Staff reported that now there was an agreed plan, morale had improved. Staff reported being consulted on the service redesign process.

Commitment to quality improvement and innovation

- Both Hollybrook and Westridge had been members of the Accreditation for Inpatient Mental Health Services organised by the Royal College of Psychiatrists' Centre for Quality Improvement for learning disabilities. They had not renewed their membership, due to the uncertainty around the service redesign.

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
Accommodation for persons who require nursing or personal care 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 Regulation 13 HSCA (RA) Regulations 2014 – Safeguarding service users from abuse and improper treatment Staff did not understand the procedures relating to seclusion and the derogation of seclusion policy. Seclusion practice was inappropriate. When patients were using the seclusion rooms, without being secluded, there were no robust care plan that ensured patients were not being secluded appropriately and aware of their rights. Records were not accurate or up to date records of the use of seclusion rooms for non-seclusion purposes. Staff did not follow the trusts policy on the administering of covert medication. This is a breach of regulation 13(1)(2)(4)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 Regulation 11 HSCA (RA) Regulations 2014 – Need for consent

This section is primarily information for the provider

Requirement notices

Consent was not reviewed regularly and all appropriate people were not included in relevant meetings.

This is a breach of regulation 11(1)