Old Leigh House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated Old Leigh House as requires improvement:

- Staff did not always follow the provider's policy and procedure for observing patients. We found gaps in the recording of observations and incidents of staff being on enhanced observations for more than two hours against the provider's policy.
- Managers did not always make notifications to the Care Quality Commission following incidents or after safeguarding concerns had been raised. We reviewed 13 records of incidents and safeguarding referrals and found staff had failed to notify the Care Quality Commission about four incidents.
- The provider's ligature risk assessment was not accurate.
- Staff and patients did not always have access to a full range of rooms to support treatment. The clinic room did not have space for an examination couch to carry out physical health checks. There were no separate rooms for individual therapy sessions or one to one time with patients. The provider did not have a quiet area for patients to see visitors. Patients' saw visitors in their bedroom or went out to spend time with them privately.

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well, managed medicines safely. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging. Staff ensured that patients had good access to physical healthcare including access to specialists when needed. We saw evidence in care records that staff referred patients to dentists, opticians, and epilepsy specialists.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability (and/or autism) and in line with national guidance about best practice.
- Staff communicated with patients so that they understood their care and treatment. Staff involved patients where appropriate, in discussions about the service. Staff held regular community meetings with patients. Staff made adjustments for patients with communication needs. All patients had communication passports that had been completed with the input of the speech and language therapist. The provider met the accessible information standards. The provider displayed information in easy read format and staff were able to provide patients with copies of their care plan in easy read formats.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	**Requires improvement** 	See below for details.

Summary of findings

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Requires improvement

Old Leigh House

Services we looked at

Wards for people with learning disabilities or autism;

Summary of this inspection

Background to Old Leigh House

Old Leigh House is a seven bed, hospital providing a service for adult men run by Cygnet (OE) ltd. The service is for people who have a learning disability, mental health needs, and may have complex needs. Old Leigh House provides a service for informal/voluntary patients and formal patients detained under the Mental Health Act 1983.

The Hospital did not have a registered manager. However, they have a service manager in place who has applied to the Care Quality Commission to become the registered manager.

We last inspected the hospital on 16 May 2017. We rated the hospital as good in all domains.

During the previous inspection we identified the below actions the provider should take:

- The provider should ensure staff adhere to their policy on supervision.
- The provider should ensure families and carers are involved in patients care and that they document this in their care records.
- The provider should ensure that staff understand the organisations visions and values and that these are embedded in the hospital's objectives.

Our inspection team

Our team consisted of two inspectors and a specialist advisor with experience of working with adults with learning disabilities and autism.

Why we carried out this inspection

We carried out a focussed unannounced inspection of this service due to concerns following two incidents the provider notified the Care Quality commission of regarding patients on escorted leave.

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 that we held about the location.

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with the service manager
- spoke with four other staff members; including a registered nurse, speech and language therapist, activities coordinator, and pharmacist
- Looked at five care and treatment records of patients
- carried out a specific check of the medication management and reviewed medication administration charts of six patients, and

Summary of this inspection

- looked at a range of policies, procedures and other documents relating to the running of the service.

We were unable to speak to any family members or carers.

What people who use the service say

- Patients told us that staff were kind, caring, and treated them with dignity and respect.
- Patients told us that the food was of good quality and that they had a choice. Patients said that if they did not want what was on the menu then the staff would try to provide an alternative.
- Patients told us that they were involved with their care. They told us they were encouraged to attend care review meetings and that staff involved them in their care plans.
- Patients told us that they were involved in decisions about the service. They told us that they had regular community meeting in which they could make suggestions for the menu and the activity programme.
- Patients told us they were not allowed to smoke or have food and drink after 22:00.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff did not always follow the provider's policy and procedure for observing patients. We found gaps in the recording of observations and incidents of staff not following the provider's policy of not being on enhanced observations for more than two hours.
- The ligature risk assessment was not accurate. The assessment stated that the bathrooms had anti ligature tap fittings which were not present during our tour of the ward environment.

However,

- All ward areas were clean, had good furnishings and were well maintained. The clinic room was fully equipped with easily accessible resuscitation equipment and emergency drugs. Staff followed good practice in medication management. Staff kept medication securely in the clinic room. We reviewed the medication administration records for all patients. We found that staff administered medication appropriately and in line with the Nursing and Midwifery Council standards for medication administration.
- Staff did a risk assessment of every patient prior to admission. We reviewed the records of five patients. Each patient had a risk assessment completed as part of the initial assessment.

Are services effective?

Good

We rated effective as Good because:

- Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Managers provided staff with supervision. We reviewed

Summary of this inspection

the supervision records which showed a compliance rate of 81%. Staff compliance with annual appraisals was 71%. We reviewed the records of five staff which included annual appraisals.

- Staff held regular multidisciplinary team meetings. The doctor visited the hospital every two weeks to carry out patient reviews. Staff had effective working relationship with teams outside the organisation. Staff told us there were good links between the service and the local authority safeguarding team.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.
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However,

- Registered nurses were unable to tell us what best practice guidance they used to plan and deliver care. Registered nurses were unaware of the National Institute for Health and Care Excellence guidance on learning disabilities and behaviours that challenge or autistic spectrum disorder in adult's: diagnosis and management guidance.

Are services caring?

Good

We rated caring as Good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as Good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.

Summary of this inspection

- Patients' were able to personalise their rooms. We saw evidence that patients had brought their own bed linen and had brought electrical items and posters to personalise their rooms. Patients had somewhere secure to keep their belongings. Each bedroom had a lockable cupboard for securing valuables.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However,

- Staff and patients did not always have access to a full range of rooms to support treatment. The clinic room did not have space for an examination couch to carry out physical health checks. There were no separate rooms for individual therapy sessions or one to one time with patients. The provider did not have a quiet area for patients to see visitors. Patients' saw visitors in their bedroom or went out to spend time with them.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Managers did not always make notifications to the Care Quality Commission following incidents or after safeguarding concerns had been raised. We reviewed 13 records of incidents and safeguarding referrals and found staff had failed to notify the Care Quality Commission about four incidents.
- Staff were not familiar with senior leaders within the organisation. Staff told us that the service manager and regional leaders were visible but leaders higher up in the organisation did not visit the hospital.

However,

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

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.

- Staff had received training in the Mental Health Act. Staff training compliance was 95%. Staff had a good understanding of the Mental Health Act and were able to access a copy of the Mental Health Act Code of Practice to refer to for guidance.
- Staff explained patients' rights under the Mental Health Act in a way they could understand. Staff used the provider's easy read information on rights to explain to patients. Staff explained rights to patients under the Mental Health Act monthly. We saw evidence of this in care records.
- Staff ensured that patients were able to take section 17 leave when the consultant had granted it. We reviewed the records of patients. We reviewed the records of patients leave. Patients were able to go out regularly once the consultant had granted leave.
- Staff requested an opinion from a second opinion appointed doctor when necessary. We saw evidence in the mental health records that staff assessed detained patient's capacity to consent to treatment. Staff requested the opinion of a second opinion appointed doctor if patients were assessed to not have capacity.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training in the Mental Capacity Act. Staff compliance with Mental Capacity Act training was 95%.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and knew how to access it.
- Staff knew where to get advice from the provider regarding the Mental Capacity Act. Staff we spoke to told us that they could get advice from the Mental Health Act administrators.
- Staff took all practicable steps to enable patients to make their own decisions. We saw evidence where staff had discussions with patients and provided them with information to enable them to make informed choices.
- Staff had assessed and recorded patient's capacity to consent appropriately. We saw evidence in the care records where staff had completed capacity assessments. Staff completed assessments on a decision specific basis.
- Staff made decisions in the patient's best interests if they lacked capacity. We saw evidence in the care records where staff held best interest decision meetings. Staff invited all relevant people to attend including families and carers.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Requires improvement

Wards for people with learning disabilities or autism

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

Staff completed regular risk assessments of the care environment. We reviewed the environmental risk assessment which included the ligature risk assessment and saw that staff reviewed these every six months. However, the ligature risk assessment stated that the bathrooms had anti ligature tap fittings which were not present during our tour of the ward environment. The manager told us that these were due to be updated. We reviewed the maintenance log and saw that the provider had plans to update these fittings, but the work had not been completed. Staff were aware of the risks and would use observations to manage the risk if a patient was at risk of ligature.

The ward layout did not allow staff to observe all areas. The provider had installed curved mirrors in the stair wells and on the upper floors to mitigate the risk of blind spots.

Staff had access to alarms. The provider had a pinpoint alarm system and there were panels around the ward, so staff could easily locate where the alarm had been activated. The patients did not have access to alarms to summon assistance if required. There were staff in communal areas who would be able to hear if a patient called out to help.

All ward areas were clean, had good furnishings and were well maintained. The provider had a house keeper who regularly cleaned the environment. We reviewed the cleaning records and saw that they were completed appropriately.

Staff adhered to infection control principles. There were hand washing facilities around the ward area as well as hand sanitiser.

The clinic room was fully equipped with easily accessible resuscitation equipment and emergency drugs. Staff checked these daily. We reviewed the audit for the past three months and saw that staff completed these appropriately.

Staff maintained equipment and kept it clean. We reviewed the cleaning record and saw that staff cleaned equipment regularly.

Safe staffing

The provider had sufficient staff to provide safe care and treatment. The provider had a staff establishment of four whole time equivalent registered nurses and 12 whole time equivalent unregistered staff. There was one vacancy for a registered nurse and no vacancies for unregistered staff. The provider only used bank and agency staff to cover increased patient observations. The provider had four agency healthcare assistants block booked to promote continuity.

The manager told us staffing numbers were calculated at head office and that this was planned around the annual budget. The manager could increase staff numbers to maintain the safety of the service for example, if there was increased levels of patient observations.

Requires improvement

Wards for people with learning disabilities or autism

Each shift required a minimum of one registered nurse and four unregistered staff. We reviewed the duty rotas for the past three months and saw that the provider regularly increased staff numbers due to patient's observation levels.

Agency staff received an induction and were familiar with the ward. We reviewed the files of agency staff and saw that they had an induction which included reading patients risk assessments and care plans.

A qualified nurse was always present on the ward. We checked the duty rota for the past three months and saw that there was always a qualified nurse on shift.

Staffing levels allowed patients to have regular one to one time. We spoke to three patients who told us that staff were always available if they wanted to speak to someone.

Staff shortages rarely resulted in staff cancelling escorted leave or activities. Patients told us that leave would only be cancelled due to clinical reasons or staff rearranged leave at an alternative time.

There was enough staff to carry out physical interventions. Duty rotas showed that there was always enough staff should they have to intervene physically to maintain patient safety. Staff had received training in de-escalation and the management of violence and aggression.

There was adequate medical cover day and night. The provider had a consultant psychiatrist and out of hours cover was managed through an on-call rota. Doctors were able to attend the service within an hour if required. In the case of emergency staff would call an ambulance.

Staff had received and were up to date with mandatory training. We reviewed the mandatory training records and saw that staff compliance was 96%.

Assessing and managing risk to patients and staff

Staff completed a risk assessment of every patient prior to admission. We reviewed the records of five patients. Each patient had a risk assessment completed as part of the initial assessment. Staff updated risk assessments as part of patients' fortnightly care review or following an incident or change of need.

Staff used the provider's risk assessment tool. This covered a range of risks including violence and aggression, self harm, suicide and self neglect.

Staff were aware of and dealt with specific risk issues such as choking and falls. We saw evidence in patients' care records were staff had assessed a patient's risk of choking and implemented a plan to manage this.

Staff did not always follow the provider's policy and procedure for observing patients. We reviewed the observation records for patients for the previous month and found that there were seven gaps in recording where staff had not signed to say they had completed the observation. We found that staff had breached the provider's policy of not being on enhanced observations for more than two hours. We found evidence that on two occasions staff had signed to say they were on observations for three hours and seven hours consecutively.

The provider told us there were no blanket restrictions in place in the service. However, we spoke to three patients two of which told us about restrictions on access to smoking and food and drink at night. The provider gave us a copy of their restrictive practices audit dated 13 January 2020, which stated that patients had access to food and drink during the day, but did not include access during the night. The audit stated smokers could access the garden after sundown but also stated there were no smokers in the service. We reviewed the care plan for one patient regarding smoking and this stated they agreed to having a cigarette hourly but did not state that this covered a 24 hour period. We were therefore unclear about the providers practices in this area.

Informal patients could leave at will and were aware of this. Patients we spoke to told us that they were aware or their right to leave. However, the provider did not have a sign displayed informing informal patients of their right to leave. We brought this to the attention of the manager who rectified this whilst we were on site.

The provider did not have a seclusion room and did not use seclusion as an intervention. The provider did not use segregation as an intervention.

The provider had low rates of restraint. We reviewed the incident records over the past 12 months. We found five incidents of restraint in this time. Staff had good de-escalation skills and only used physical restraint as an absolute last resort.

The provider did not use rapid tranquilisation as an intervention.

Requires improvement

Wards for people with learning disabilities or autism

Safeguarding

Staff were trained in safeguarding and knew how to make a safeguarding alert when appropriate. Staff compliance with safeguarding training was 100%. We reviewed eight safeguarding records and saw that staff were making referrals to the local authority safeguarding team where appropriate. However, staff had not notified the Care Quality Commission of all notifiable safeguarding concerns.

Staff could give examples of how they protect patients from harassment and discrimination. Staff told us there was always staff in the communal areas and they supported patients in the community if appropriate.

Staff knew how to identify if patients were at risk of or suffering significant harm. All staff we spoke to were able to explain what signs they would look out for and what action they would take.

The provider did not allow children on the ward. If a patient was being visited by family with a child, they would have to go off the ward to see them. Staff would complete a risk assessment of patients and ensure they were safe to go out with family prior to arranging the visit.

Staff access to essential information

Staff had access to all information needed to deliver care. The provider used paper records and all staff, including bank and agency staff had access to these. Staff told us that the provider had plans to introduce their electronic records system in the future.

Patient information was accessible to all relevant staff. Records were kept secure in a locked cupboard in the staff office.

Medicines management

Staff followed good practice in medication management. Staff kept medication securely in the clinic room. We reviewed the medication administration records for all patients. We found that staff administered medication appropriately and in line with the Nursing and Midwifery Council standards for medication administration. Staff used a local pharmacy for medication reconciliation. A pharmacist attended the service each week to audit the medication and check stock levels.

Staff reviewed the effects of medication on patient's physical health. Staff used a recognised rating scale to monitor patients for side effects. We saw evidence in patients' records that staff performed annual physical health monitoring in line with the National Institute for Health and Care Excellence guidance, Psychosis and schizophrenia in adults: prevention and management.

Track record on safety

The provider had one serious incident in the past 12 months. We checked the incident report and investigation and saw that staff had managed this appropriately.

The provider had one adverse event in the past 12 months. The telephone lines stopped working in the service. The manager had the phone lines diverted to her mobile phone, so people could still contact the service.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. All staff we spoke to were able to tell us what incidents they would report and that they reported incidents on the providers on line reporting system.

We reviewed the incident reporting log for the past 12 months and saw that staff reported all incidents they should.

Staff understood the duty of candour. Staff were open and honest and explained to patients and their families when thing went wrong. Staff gave patients and their families a full explanation and apologised when necessary. Staff had not reported all reportable incidents to the care quality commission. We found four incidents that were not reported.

Staff received feedback from the investigation into incidents. Staff told us that they share information during team meetings. We reviewed the minutes of team meetings and saw that lessons learned from incidents was a standard agenda item.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Requires improvement

Wards for people with learning disabilities or autism

Staff completed a comprehensive mental health assessment of patients prior to admission. We reviewed five patients care records that contained detailed assessment of patients' mental health and their risks and needs. Staff information gained during the assessment was included within the care planning process.

Staff completed an assessment of patients' physical health needs in a timely manner after admission. Staff completed a physical healthcare as part of the admission process. We saw evidence in the care records staff completed this for each patient.

Staff developed care plans that met the needs identified during the assessment. We reviewed the care plan of five patients and saw that these met a variety of needs identified in the assessment process. Care plans are personalised and written in a language that was easy for patients to understand. Care plans were holistic, and recovery orientated. Staff reviewed, and updated care plans following care review meetings which occurred every two weeks.

Best practice in treatment and care

Staff provided a range of interventions suitable for the patient group, such as positive behaviour support plans. Each patient had a positive behaviour support plan which explained about the patient's presentation and how best to support them. Staff had written care plans in a way that demonstrated best practice in providing strategies and interventions for aiding communication using communication passports which had been completed with the support of the speech and language therapist. care plans demonstrated that staff were providing person centred care. We spoke to two qualified staff who were unable to tell us what best practice guidance they used to plan and deliver care. Staff were unaware of the National Institute for Health and Care Excellence guidance on learning disabilities and behaviours that challenge or autistic spectrum disorder in adult's: diagnosis and management guidance. However, we reviewed policies regarding care and treatment such as medication management and restraint and saw that they reflected best practice guidance.

Staff ensured that patients had good access to physical healthcare including access to specialists when needed. We saw evidence in care records that staff referred patients to dentists, opticians, and epilepsy specialists.

Staff assessed and met patients' needs food and drink are specialist nutrition and hydration. We saw evidence that a speech and language therapist had assessed patients' swallowing difficulties and staff provided a soft diet.

Staff used recognised rating scales to assess and record severity and outcomes. We saw evidence in care records that staff used the health of the nation outcome scales as well as the antipsychotic side effect assessment.

Skilled staff to deliver care

The team consisted of a range of staff disciplines and they had access to specialists required to meet the needs of patients. Staff were able to access speech and language therapists, psychologists, occupational therapists and pharmacists.

Staff were experienced and had the necessary skills and experience to meet the needs of the patients. Managers provided staff with an appropriate induction which allowed staff to complete mandatory training and to shadow experienced staff to enable them to learn their role. Staff had received training in learning disabilities and autism spectrum disorder. However, we did not see evidence that this had been provided for agency staff. We reviewed the files for two regular agency staff and saw evidence of mandatory training but not for specialist training.

Managers provided staff with supervision. We reviewed the supervision records which showed a compliance rate of 81%. This was below the providers target of 93 %. The manager was in the process of implementing a supervision tree where senior staff supervise those staff on a lower grade to improve compliance.

Managers ensured that staff had access to regular team meetings. We reviewed the team meeting minutes for the past six months and saw that these happened monthly.

Staff compliance with annual appraisals was 71%. This was below the provider's target of 93%. We reviewed the records of five staff which included annual appraisals. We saw evidence that managers identified learning needs of staff and provided them with opportunities to develop their skills.

Managers dealt with poor performance promptly and effectively. We saw evidence of staff supervision when managers had issues around staff arriving late.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary team meetings. The doctor visited the hospital every two weeks to carry out patient reviews. We saw evidence in patients care records that staff reviewed their care regularly.

The staff team had effective working relationships, including good handovers. We reviewed the handover records and saw that handovers were meaningful, and staff shared information regarding patient presentation throughout the day.

The staff team had effective working relationship with teams outside the organisation. There were good links between the service and the local authority safeguarding team. Staff told us that they had good contacts with community mental health and learning disability teams and they attended care review meetings.

Adherence to the MHA and the MHA Code of Practice

Staff had received training in the Mental Health Act. Staff compliance with training was 95%. Staff had a good understanding of the Mental Health Act and were able to access a copy of the Mental Health Act code of practice they need to refer to it for guidance.

Staff had access to administrative support and legal advice on implementation of the Mental Health Act. Staff could contact the provider's Mental Health Act administrators should they need advice and support.

Patients had easy access to information about independent mental health advocacy. Information was displayed on noticeboards throughout the service.

Staff explained patients' rights under the Mental Health Act in a way they could understand. Staff used the provider's easy read information to explain rights to patients. Staff explained rights to patients under the Mental Health Act monthly. We saw evidence of this in care records.

Staff ensured that patients were able to take section 17 leave when the consultant had granted it. We reviewed the records of patients. We reviewed the records of patients leave. Patients were able to go out regularly once the consultant had granted leave.

Staff requested an opinion from a second opinion appointed doctor when necessary. We saw evidence in the mental health records that staff assessed detained patients' capacity to consent to treatment. Staff requested the opinion of a second opinion appointed doctor if a detained patient was assessed to not have capacity.

Staff stored copies of patients' detention papers and associated records, so all staff had access to them. Staff kept these records in the manager's office. Staff could request access when needed.

The service did not display a notice to tell informal patients they could leave the ward freely. We informed the manager who took immediate action to rectify the situation.

Good practice in applying the MCA

Staff had received training in the Mental Capacity Act. Staff compliance with Mental Capacity Act training was 95%.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty safeguards. Staff were aware of the policy and knew how to access it.

Staff knew where to get advice from the provider regarding the Mental Capacity Act. Staff we spoke to told us that they could get advice from the Mental Health Act administrators.

Staff took all practicable steps to enable patients to make their own decisions. We saw evidence where staff had discussions with patients and provided them with information to enable them to make informed choices.

Staff had assessed and recorded patients' capacity to consent appropriately. We saw evidence in the care records where staff had completed capacity assessments. Staff completed assessments on a decision specific basis.

Staff made decisions in the best interests of patients if they lacked capacity. We saw evidence in the care records where staff held best interest decision meetings. Staff invited all relevant people to attend including families and carers.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff completed audits to ensure that documentation was completed appropriately.

Requires improvement

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. We spoke with three patients who told us staff respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff supported patients to understand and manage their care, treatment, or condition. We saw evidence in care records that staff regularly spent one-to-one time with patients to discuss their needs and their treatment.

Staff directed patients to other services when appropriate and supported them to access the services. We saw evidence in care records where staff had referred one patient and supported them to access a college course.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Staff we spoke to were able to tell us about individual patient needs and how they met them.

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of any consequences. Staff told us that the manager would listen to concerns and take action.

Staff maintained the confidentiality of information about patients. Staff kept all information locked securely within the staff office.

Involvement in care

Staff used the admission process all orientate patients to the ward and the service. Patients told us staff showed them around and introduce them patients and staff also provide patients with a welcome pack contains information about the service, local area, and the activity plan.

Staff involved patients in the planning of their care. Patients told us that they were regularly involved in their care and attended regular care review meetings.

Staff communicated with patients so that they understood their care and treatment. We saw evidence in the care records that staff used easy read care plans and documentation enable patients to understand their care.

Staff involved patients where appropriate in discussions about the service. Staff held regular community meetings with patients. This enabled patients the opportunity to give feedback on the service development and improvement such as changes to the activity schedule or to the menu.

Staff ensured patients had access to advocacy services. Information on local advocacy services was displayed throughout the service. Advocates visited the service weekly.

Staff informed and involved families and carers appropriately and provided them with support when needed. Patients told us staff kept their families informed and involved them in their care. Patients told us that their families and carers were invited to their care review meetings. We saw evidence in patients review meeting records that family and carers were present.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Beds were available when needed for patients living in the catchment area. The provider admitted patients mostly from the Essex area. There was one vacancy at the time of inspection.

There was always a bed available when patients returned from leave. Staff did not admit patients into leave beds.

The service had one patient who was delayed discharge in the past 12 months. This was due to not finding an appropriate placement.

Staff planned for patients discharge, including liaising with care coordinators. Staff invited care coordinators to care

programme approach review meetings and care and treatment reviews. We saw evidence in patients' care records that staff included discharge planning in patients' care reviews.

Staff supported patients during referrals and transfers between services. We saw evidence in care records that staff were supporting a patient to visit the service where they were due to be discharged to.

The facilities promote recovery, comfort, dignity and confidentiality

Patients' were able to personalise their rooms. We saw evidence that patients had brought their own bed linen and had brought electrical items and posters to personalise their rooms.

Patients had somewhere secure to keep their belongings. Each bedroom had a lockable cupboard for securing valuables.

Staff and patients did not always have access to a full range of rooms to support treatment. The clinic room did not have space for an examination couch to carry out physical health checks. Staff told us that they would do this in the patient's bedroom to ensure they maintained patients' privacy and dignity. There were no separate rooms for individual therapy sessions or one to one time with patients. Group activities took place in the dining room area. Staff saw patients for one to one sessions in private in their bedrooms.

The provider did not have a separate private area for patients to see visitors. However, patients were able to see visitors privately in their bedrooms or they would go out with their visitors. Patients told us they were happy with these arrangements.

Patients could make private phone calls. Patients had access to their mobile phone if they had been risk assessed as being safe to do so.

Patients had access to outside space. The provider had a small safe and accessible garden area where patients could go to get fresh air.

The food was of good quality. Patients told us that they enjoyed the food and there was always a choice. Patients told us they had input into the menu during community meetings. The chef attended, and the patients would make suggestions of what they would like on the menu.

Patients' engagement with the wider community

Staff ensured patients had access to education and work opportunities. We saw evidence in a patient's records that staff were supporting them to attend a college course. Staff would take patients out to do activities in the community such as swimming, cinema and shopping.

Staff supported patients to maintain contact with families and carers. We saw evidence of staff supporting patients to go and visit family. Staff ensured patients detained under the Mental Health Act had Section 17 leave to see family outside of the service, where appropriate.

Meeting the needs of all people who use the service

The service had made adjustments for disabled patients. There was a bedroom on the ground floor and there was enough space on the ground floor for someone to manoeuvre a wheelchair. Staff had made adjustments for patients with communication needs. All patients had communication passports that had been completed with the input of the speech and language therapist. The provider met the accessible information standards. The provider displayed information in easy read format and staff were able to provide patients with copies of their care plan in easy read formats. This included information on advocacy, how to complain and information on local services.

Staff could access information in different languages if required. There were no patients, at the time of the inspection, whose first language was not English.

Staff were able to access an interpreter when required. Staff had access to contact details for an interpreter service.

Patients had a choice of food. Patients told us there was always different options and if they did not want what was on the menu the chef would always try to accommodate them. The chef was able to offer a choice of food for patients' religious or cultural needs.

Staff ensured that patients had access to appropriate spiritual support. There was a local church that patients had attended, and staff could contact local mosques or synagogues if required.

Listening to and learning from concerns and complaints

Patients knew how to make a complaint. The provider displayed information on how to make a complaint.

Requires improvement

Wards for people with learning disabilities or autism

Patients' we spoke to told us they were aware of the process for making a complaint and they would be happy to do so. Patients told us that they felt that staff would manage complaints appropriately.

Staff knew how to handle complaints. Staff told us that they would take the details of the complaint and share it with the manager who would then investigate and respond. The provider had received one complaint in the past year. We reviewed the records and saw that this staff investigated and responded to this appropriately and in line with the providers policy.

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

Requires improvement

Leadership

Leaders had the skills and knowledge to perform their role. We spoke to leaders at the hospital who demonstrated good knowledge and understanding of the service. They were able to explain how the team worked to provide high quality care. Staff told us they felt the leaders were supportive and approachable.

Leaders were visible within the service. Staff told us that the manager was always available and that the regional director often visited the ward. However, staff were not familiar with leaders higher up within the organisation. Staff told us they did not visit the service.

The provider offered leadership development opportunities. The manager told us they were aware of these but had not accessed them yet.

Vision and strategy

Staff were aware of the organisation's visions and values. Staff told us they had training on values, behaviours and culture. Staff told us that their work empowers patients to grow and develop independence. They treated patients with respect and they cared about their work.

Staff had the opportunity to contribute to discussions about changes to the service. The provider is currently looking to change their registration from a hospital to a residential care home. We saw evidence in team meetings that the staff had been involved in discussions about the change.

Culture

Staff felt respected, supported and valued. Staff told us that managers had an open door policy and they could speak to the manager anytime if they had issues. Staff felt that managers supported the team well and valued the work of staff.

Staff felt able to raise concerns without fear of retribution. Staff told us that they could speak to the manager about their concerns and that the manager would respond appropriately.

Staff knew how to use the provider's whistle blowing policy. Staff told us they could raise concerns through the freedom to speak up guardian.

Manager dealt with poor staff performance promptly and appropriately. We reviewed staff supervision record and saw that the manager had dealt with issues of punctuality appropriately using the providers performance management policy.

Staff reported that the provider promoted equality and diversity in its every day work and in providing opportunities for career progression.

Governance

There was a clear framework of what must staff must discuss at team and governance meetings to ensure they share essential information. We reviewed the minutes of team and governance meetings and saw that lessons learned from incidents and complaints was a standard agenda item. Information from the governance meeting regarding lessons learned from other locations was shared during team meetings so that lessons learned were shared throughout the organisation.

Staff undertook and participated in clinical audits. Staff were responsible for completing audits on medical equipment, care plans, risk assessments and the hospital environment. We reviewed the audits and found that staff had completed these appropriately.

Management of risk, issues and performance

Requires improvement

Wards for people with learning disabilities or autism

Staff were able to submit items to the provider's risk register. Staff told us they would inform the manager who would then decide whether it they would put it on the risk register. We reviewed the risk register and saw that the risks were pertinent to the provider.

The service had plans for emergencies such as adverse weather or a flu outbreak. We reviewed the emergency plan and saw that it contained appropriate plans to deal with emergencies.

Information management

Staff had access to the equipment they needed to do their work. However, the service had not implemented the provider's hospitals computerised records system as they were waiting until they had deregistered as a hospital and reregistered as a residential home before implementing the provider's social care computer system.

Information governance systems included confidentiality of patient records. Staff kept patient information securely and only shared on a need to know basis.

The manager had access to information to support them with their management role. Information on the performance of the service was available on line and the manager kept their own records for ease of access.

Managers did not always make notifications to the Care Quality Commission following incidents or after safeguarding concerns had been raised. We reviewed 13 records of incidents and safeguarding referrals and staff had not notified the Care Quality Commission about four. However, staff had sent all safeguarding referrals to the relevant local authority.

Engagement

Patients and carers had opportunities to give feedback on the service they received. The provider conducted patient and carer surveys annually.

Patients and staff could meet the regional senior leaders. However, staff told us that senior leaders from higher up in the organisation never visited the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff follow its policy for enhanced therapeutic observations of patients. (regulation 12 (2) (b))
- The provider must ensure that they notify the Care Quality Commission of all notifiable incidents and safeguarding concerns. (regulation 18 (2) (e))

Action the provider SHOULD take to improve

- The provider should ensure that staff are up to date with best practice guidance.
- The provider should ensure their ligature risk assessment accurately reflects current risks and mitigation for identified risks.
- The provider should ensure there are private spaces for patients to receive therapeutic one to one therapy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents