

Requires improvement 

Leicestershire Partnership NHS Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RT5FP	1&2 The Grange	Short Breaks	LE3 9QF
RT5FM	Rubicon Close	Short Breaks	LE12 7DJ
RT5NH	Agnes Unit	Wards for people with learning disabilities	LE7 7GL

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- The short stay services did not comply with the guidance on the elimination of mixed sex accommodation. There were no separate female bedroom areas and no gender specific toilets or bathrooms. Bathrooms and toilets were specified for which gender depending on who was resident at the unit at the time. This was done by sliding signs to the door as needed.
- Shifts were not always covered with sufficient staff, or with staff who had the appropriate qualification and experience for the role.
- Staff were not supervised in line with the trust's policy. The overall average compliance rate for supervision of staff in the learning disability wards was 46%.
- Staff did not adhere to the Mental Capacity Act Code of Practice and the five principles of the Act. Capacity assessments were not decision specific. Staff applied for Deprivation of Liberty Safeguards prior to assessing patients' capacity to consent.

However:

- Staff completed and regularly reviewed and updated comprehensive risk assessments.
- Staff completed extensive and detailed care plans. Patients were involved in the writing of their care plans and their views were reflected in the plans. Staff used "my care plan" documents to obtain patients' views on their care. Plans were shared with family and carers.
- Staff were kind, caring and compassionate and treated patients with dignity and respect. Patients felt safe.
- Staff reported morale was good, they worked well together and supported one another.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- The short stay services did not comply with the guidance on the elimination of mixed sex accommodation. There were no separate female bedroom areas and no gender specific toilets or bathrooms.
- Managers were not always able to cover shifts with qualified nursing staff. In June 2016, 29% of shifts for qualified staff were not filled for day shifts and 44% for night shifts.
- There were blind spots on all wards. At the Agnes unit, all pods had blind spots in the bedroom areas. The trust had not mitigated these through the use of mirrors.

However:

- All wards were clean, tidy and well maintained. The furniture was in good condition.
- Staff undertook comprehensive risk assessments. Staff updated these on a regular basis and following incidents.
- The Agnes unit had low rates of restraint and seclusion. Staff at the Agnes unit received management of actual and potential aggression (MAPA) training. Staff at the short stay units received SCIP-UK training (strategies for crisis intervention prevention). This is a specialist training that looks at challenging behaviours and the causes of these. This taught staff to de-escalate patients with challenging behaviours effectively.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

- In the last six months, only 32% of staff at the Agnes unit and 61% of staff at the short stay services received supervision.
- Over the last year, only 67% of staff at the Agnes unit and 81% of staff at the short stay services had had an appraisal.
- Only 61% of Staff had received training on the Mental Health Act.
- Staffs compliance with Mental Health Act training, was 61%.
- Staff did not always adhere to the principles of the Mental Capacity Act. Mental capacity assessments were not always decision specific. Two patients did not have a mental capacity assessment for consent to treatment.

Requires improvement



Summary of findings

- Staff did not adhere to the Mental Capacity Act Code of Practice when applying for Deprivation of Liberty Safeguards (DoLS). Staff at the short stay services applied for DoLS for each patient prior to assessing the patient's capacity.

However:

- Staff completed an assessment of patients prior to admission to check their suitability for the service. Staff used this information to write holistic care plans which covered physical healthcare, manual handling needs and tissue viability needs.
- Staff regularly monitored patients' physical health, and promoted access to health care services such as GPs as required.
- There were good multidisciplinary team (MDT) meetings which were attended by all staff disciplines.

Are services caring?

We rated caring as good because:

- Staff were kind, caring and compassionate and treated patients with dignity and respect.
- Patients were involved in the planning of their care. Care plans showed that staff had tried to involve patients where possible and care plans reflected this. Staff used "my care plan" documents to gain information about patients and these were sent to families and carers for their input.
- Patients had access to advocacy when needed. The provider used a local advocacy service and information about this service was displayed around the wards.
- Staff understood and explained the individual needs of patients. They explained how the service met these needs.
- The trust had involved patients' carers in recruitment processes, including staff interviews.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- The average length of stay for The Agnes unit over the past 12 months was 134 days and six days on the short stay services.
- Beds were available for patients living in the catchment area. Staff did not use patient's beds when they were on leave.
- The Agnes unit had a wide range of rooms available. There were quiet rooms where patients could see visitors. There was a therapy kitchen and a range of different activity rooms for therapeutic activities.

Good



Summary of findings

- Patients were able to personalise their rooms. Some patients had brought in their own bed linen and had displayed posters of their choice.
- Activities were available seven days a week. The occupational therapy team provided activities Monday to Friday. The therapy team offered timetabled activities in the evenings and at weekends and the ward staff provided some activities at weekends.
- Information leaflets were available in different languages as well as easy read format. We saw some very good easy read medication information leaflets.

However:

- Menus were planned two weeks in advance and there was not sufficient food should someone change their mind. However, at the short stay services food was cooked fresh on the ward and we saw evidence that specialist dietary requirements were accommodated.
- Patients did not have access to a private telephone. Staff facilitated patient phone calls with the ward cordless phone. Patients wishing to have privacy were allowed to use this in their bedroom.

Are services well-led?

We rated well-led as requires improvement because:

- There was a breach of the eliminating mixed sex accommodation that had not been resolved.
- There were poor supervision rates for all wards. Managers were aware of this and looking at processes to improve supervision compliance. The manager at the Agnes unit told us they were considering ways in which they could achieve this.
- We observed a meal time at the Agnes unit and the food was of poor quality and there were insufficient quantities. The food did not always meet the dietary or cultural needs of the patients. This had not been addressed.
- There was not always enough staff of the right grade and experience to cover all shifts. The short stay services had a shift fill rate of 71% on day shifts and 56% for night shifts. The Agnes unit sometimes had one qualified nurse covering two pods. This was the case on the day of inspection. Staff were aware of the trust's visions and values. Staff told us these underpinned all the work they did with patients.

However:

Requires improvement



Summary of findings

- Staff were able to maximise their time on care activities. During inspection, we observed staff spending long periods of time on the ward interacting and working with patients.
- Senior staff investigated incidents and identified lessons learnt which were fed back to staff at team meetings. We saw evidence of this in team meeting minutes.
- There was good staff morale. Staff we spoke with told us they enjoyed their job and the team were very supportive and worked well together.

Summary of findings

Information about the service

The Agnes Unit is an assessment and treatment service for adults with learning disabilities. The unit provides an inpatient service for individuals whose mental health, behaviour and risk cannot be supported in the community.

The short stay services provides health short breaks for adults with learning disabilities and associated physical and sensory disabilities, challenging behaviours or

autism. Most stays are planned and allow family and carers to have a break from caring for their family member. At times they provide emergency care and care at short notice to service users known to their services. There were three units, The Grange, The Gillivers, and Rubicon Close. The Grange and The Gillivers were located next to each other. All three units admitted both male and female patients.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Sarah Duncanson, Inspection Manager, mental health hospitals, CQC

We visited the learning disability wards with two inspectors, a psychologist, social worker, occupational therapist and an expert by experience who has experience of using services or caring for someone who uses services.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all four wards at the three hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 12 patients who were using the service and collected feedback from eight patients using comment cards
- spoke with four family members

Summary of findings

- spoke with the managers or acting managers for each of the wards
- spoke with 18 other staff members; including doctors, nurses, health care assistants, occupational therapists, and administrators
- attended and observed two hand-over meetings and one multi-disciplinary meeting
- looked at 17 care and treatment records of patients
- carried out a specific check of the medication management on four wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 12 patients and received feedback via eight comment cards. The overall opinion was that staff treated patients well, and were very kind, caring and compassionate. Patients felt staff listened to them and treated them with dignity and respect.

Patients felt that services were very good and staff worked as a team to support patients and meet their needs.

Patients told us that staff talk to them about their care plans. Patients said that their views and opinions were included in their care plans.

Nine patients at the Agnes unit told us they did not like the food. They described it as revolting and disgusting.

We spoke with four carers. They also told us that they felt their loved ones received good care and were well looked after. They told us that staff were kind, caring and compassionate and were responsive to any queries they raised.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that all wards comply with the guidance on the elimination of mixed-sex accommodation.
- The trust must ensure that staff receive regular supervision and an annual appraisal.
- The trust must ensure that staff adhere to the Mental Capacity Act Code of Practice and to the principles of the Act.

Action the provider **SHOULD** take to improve

- The trust should ensure that wards are staffed safely with suitably qualified and experienced staff.
- The trust should ensure that the food on the Agnes unit is of good quality when presented and there is sufficient quantity to allow patients a choice.
- The trust should ensure that they are meeting the different dietary requirements of patients.

Leicestershire Partnership NHS Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Wards for people with learning disabilities	Agnes Unit
Short Breaks	1 & 2 The Grange
Short Breaks	Rubicon Close

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 Trust.

- Staff did not always receive Mental Health Act training. The overall compliance was 72%. Sixty-one per cent of staff within the short stay services and 83% at the Agnes unit had received recent training.
- Staff ensured that patients had given consent before administering treatment. Those who were unable to give consent had the appropriate paperwork attached to their medication records.
- Staff ensured they read patients their rights regularly. However, there was not a time frame for when to repeat rights if a patient did not understand them.
- Patients had access to an independent Mental Health Act advocate. The trust used a local advocacy service and information about the service was displayed around the wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Eighty-five percent of staff across the four wards had received recent training in the Mental Capacity Act.

Detailed findings

- Staff did not adhere to the principles of the Mental Capacity Act when assessing patient's capacity. Capacity assessments were not decision specific and related to all decisions.
- Staff did not adhere to the Mental Capacity Act code of conduct when applying for DoLS. Staff made DoLS applications for all patients on admission, regardless of their capacity to consent.

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

- Ward layouts did not allow staff to observe all areas. The Agnes unit was separated into four pods. In each pod there were blind spots in the bedroom areas. In the short stay services there were blind spots in the bedroom and lounge areas. Blind spots were not mitigated by the use of mirrors. Staff mitigated these risks by completing risk assessments and using increased levels of observations.
- We found ligature points in the short stay units. These included window handles, and door retainers. We reviewed the ligature risk assessment, which included all ligatures and actions staff should take to minimise the risk to patients. Actions included increasing patient's observation levels should they present a risk of ligaturing. The Agnes unit had anti-ligature fittings throughout the ward.
- The short stay service did not meet guidance on the elimination of mixed sex accommodation. The Mental Health Act Code of Practice states that; "All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms." Staff were not able to separate the bedrooms to meet mixed sex accommodation requirements. There was only one bathroom on each of the wards and one toilet used by male and female patients. Staff had not completed risk assessments or care plans regarding mixed sex accommodation.
- The clinic rooms on the Agnes unit pods were small. However, there was a separate clinic room where doctors did physical healthcare checks on patients. This room contained a bed and all the necessary equipment needed. Staff had access to resuscitation equipment and emergency drugs which staff regularly checked.
- On the short stay units, all the medication was stored in the staff office. They kept a range of equipment for physical healthcare assessment and management. They also had access to resuscitation equipment and emergency drugs, which staff checked on a daily basis. We reviewed the audits which confirmed checks were carried out daily and equipment had been serviced annually.
- The seclusion room on the Agnes unit was very large which allowed for clear observation. There was a large de-escalation area and access to outdoor space. There was a two-way communication system for the seclusion room and the whole area was temperature controlled. There was access to toilet facilities. If someone was in the seclusion room, staff would have to stand outside the door in the de-escalation area.
- Ward areas were clean, tidy and well furnished. We checked the cleaning rotas and saw that cleaning staff were present on a daily basis.
- Equipment was clean and well maintained. Staff kept records of when equipment was cleaned. We reviewed these records and saw that staff did this on a weekly basis. We reviewed the maintenance records and saw all equipment had been serviced on an annual basis.
- Environmental risk assessments had been undertaken. The trust updated these on an annual basis. We reviewed the environmental risk assessments of each area and saw that they were all up to date.

Safe staffing

- The Agnes unit establishment was 15 whole time equivalent (WTE) qualified nurses and 50.7 WTE health care assistants. There were eight vacancies for qualified nurses and 11 WTE health care assistant vacancies. The short stay service had an establishment of 14.7 WTE qualified nurses and 22.3 WTE healthcare assistants. The short stay services had 12% vacancy rate. They had several senior nurses working on the unit. All staff vacancies had been appointed to and staff were awaiting pre-employment checks before commencing employment.
- Managers were not able to cover all shifts with sufficient staff. At the short stay service in between June and

Are services safe?

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

August 2016 24 shifts were not covered. In June 2016, 28% of qualified shifts were not filled for day shifts and 43% of night shifts were not filled. In June, 28% of qualified nursing night shifts were not filled.

- Senior staff established whether or not a qualified member of staff was required by considering the needs of the patients admitted to the ward. They based this decision on factors such as physical healthcare needs of patients and any potential risk of patients. Healthcare assistants were trained in physical health care interventions. This included medication management which included the administration of as required medication and emergency treatment procedures for patients with epilepsy. This meant that there was always staff on shift trained to deal with physical health emergencies.
- The Agnes unit covered 15% of shifts with bank or agency staff. The short stay services had covered 27% of shifts with bank or agency staff. We reviewed the duty rotas and found that the trust used regular bank and agency staff to cover shifts to promote continuity of care.
- Ward managers were able to adjust staffing levels to meet the needs of the service. We saw evidence that staffing had increased when patients were placed on enhanced observations.
- Staff offered patients one to one time regularly. We spoke with 12 patients, nine of whom confirmed this.
- Managers did not cancel escorted leave or ward activities due to staffing issues. If escorted leave was planned, the manager increased staffing levels to accommodate this. The occupational therapy team planned and carried out all weekday activities. There were sufficient staffing numbers in the team to cover staff absences.
- We reviewed the duty rotas for each ward and saw that there were sufficient levels of trained staff on each shift to be able to carry out physical interventions.
- Each ward had access to medical cover during the day and night. The Agnes unit had doctors on site, and there was an on-call rota for doctors out of hours. Staff at the short stay services did not have doctors on site, but were able to access doctors at the Agnes unit.

- 3 Rubicon Close had access to local a GP service where patients were temporarily registered.
- Staffs compliance with mandatory training was 82%. Mandatory training covered 14 subjects, these included training on moving and handling, basic life support, safeguarding adults and children, The Mental Capacity Act and The Mental Health Act. There were three mandatory training courses where compliance fell below 75%. These were fire safety awareness, The Mental Health Act, and SCIP-UK (specialist training for managing challenging behaviour when working with people with learning disability). Only 18% of staff had completed SCIP-UK training.

Assessing and managing risk to patients and staff

- The Agnes unit had recorded two incidents of seclusion in the past six months. We checked these records and saw that a doctor had attended within one hour. This is in accordance with The Mental Health Act Code of Practice. The short stay service did not use seclusion.
- The Agnes unit recorded two incidents of segregation in the past six months. We checked the records for these and saw staff had documented incidents appropriately. We saw that staff had completed care plans and risk assessments for segregation. The short stay service did not use segregation.
- The Agnes unit recorded four incidents of restraint in the past six months. These incidents involved two patients. Staff had appropriately completed incident forms and updated risk assessments. None of these restraints were prone restraints and one incident required the use of rapid tranquilisation. The short stay service did not have any incidents of restraint in the past six months.
- Patients in all areas had an assessment prior to admission. However, staff on the short stay service did not always update risk assessments prior to subsequent admissions. Staff told us that they would update the risk assessment at the end of someone's admission and update the family on any changes they had observed. We found two risk assessments that staff had not updated. One of which had not been updated since October 2015. Staff on the Agnes unit updated risk assessments on a regular basis.
- Staff completed risk assessments using the trusts risk assessment tool on the computer record system.

Are services safe?

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

- Blanket restrictions were only used when justified and in line with the trust's policy. These were mainly around smoking times in order to promote engagement with therapeutic activities.
- Informal patients were free to leave at any time. However, staff kept doors locked so informal patients had to request staff let them out. However, there were no posters to inform patients of this.
- Wards had policies and procedures for the use of observations. Staff increased observation levels for patients presenting with high risk behaviours. Staff used different levels of observations to promote safety of patients.
- Staff only used restraint after de-escalation had failed. Staff at the short stay units were trained in SCIP-UK, which is specific to people with learning disabilities. It focuses on de-escalating challenging behaviour, and uses restraint as a last resort. Compliance with this training was only 18%. Staff on the Agnes unit were trained in managing actual and potential aggression (MAPA). However, staff on Agnes unit rarely used restraint to manage challenging behaviour.
- Staff followed Nice (National Institute for Health and Care Excellence) guidelines for administering rapid tranquilisation. Staff had only used rapid tranquilisation once in the past six months. We checked the care records and saw that staff had completed all physical health monitoring as required by NICE guidelines.
- Staff received training in safeguarding and knew how to make safeguarding referrals when appropriate. Staff were 89% compliant with safeguarding adults and children training. We spoke with 20 staff who were able to describe how to identify abuse and refer this to safeguarding.
- There were good medicines management procedures in place. The Agnes unit used an electronic prescribing system. This is a computer system used for the dispensing and managing of medication. Staff recorded when they had administered medication and documented any reasons why they did not give a medication. Staff accessed Mental Health Act consent to treatment forms on the system so they could check whether they were administering medication legally. The doctor reviewed medication on the computer as part of their ward rounds.
- We reviewed all the prescription charts at the short stay service. We found staff had completed medication charts and there were no gaps. Senior health care assistants at the short stay service had received training in medication management. This meant that if there was not a qualified member of staff on duty, they were able to dispense medication safely. Band three staff had undertaken additional training for the use of as required medication.
- The short stay service accommodated patients who had high physical dependency needs, which meant they were at high risk of developing pressure ulcers. The service had access to all appropriate equipment such as pressure relieving mattresses and cushions. We reviewed the turn charts of patients which confirmed staff were turning patients regularly. We saw evidence that staff documented physical health needs in care plans.

Track record on safety

- There had been no serious incidents requiring investigation between 1 July 2015 and 30 June 2016 according to data provided by the trust.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how and what incidents to report. Staff used a computerised incident reporting system. The manager investigated all incidents.
- Staff reported incidents appropriately. We reviewed the incident recording information. In the four months prior to inspection staff had reported 121 incidents. Examples of incidents included violence and assault, staffing issues, self-harm, tissue viability and slips trips and falls. Staff were open and transparent when things went wrong and informed patients and their families where appropriate.
- Staff received feedback from investigations into incidents and lessons learned. The manager shared the outcome of investigations and lessons learned during staff meetings. We reviewed the minutes of team meetings and saw this is a standard agenda item. Feedback also covered compliments.

Are services safe?

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

- The manager of the short stay service gave us an example of change coming about as a result of staff reporting incidents. The outcomes were to install air conditioning in a clinic room after staff consistently raised concerns that the temperature in the room was too high.
- Staff received a debrief and support following serious incidents. Staff at the Agnes unit told us that the service manager met with staff following incidents to offer support.

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

- Staff completed a comprehensive assessment of patients' needs as part of the admission process at the Agnes unit. At the short stay services, staff completed preadmission assessments to identify any change in needs since the last admission.
- Patients in the Agnes unit received physical health checks upon admission and we found evidence of ongoing physical health care monitoring. At the short stay services, staff contacted the patients' GP prior to admission for updated information on any change of physical health needs or medication.
- We reviewed 17 care records, each contained a holistic comprehensive assessment of patients' needs. They covered a range of needs identified in the assessments such as managing challenging behaviour, physical health care, personal care needs, and assessment of capacity. Staff reviewed and updated care plans as part of weekly care reviews. However, on Agnes unit we found one patient had been on the ward for a year and did not have a care plan. We also found one patient had not had access to their care plan.
- All information to deliver care was stored securely on an electronic system. Staff kept paper backup copies of risk assessments and care plans. These were kept securely in the nurses' office. Bank and agency staff had access to the computer system.

Best practice in treatment and care

- Doctors followed NICE guidelines when prescribing medication. We reviewed 12 patient prescription charts which showed that antipsychotic prescribing met with NICE guidelines.
- Patients at the Agnes unit had access to psychological therapies recommended by NICE. These included the use of functional assessments to identify behaviours that challenge and the use of cognitive behaviour therapy where possible. There was also access to

therapeutic activities including music and drumming, indoor games, cooking, and the use of a sensory room. This enabled patients to develop coping skills to enable safe discharge.

- There was good access to physical healthcare. At the Agnes unit, staff were able to provide physical health care interventions with the support of the doctors. We saw evidence in the care records that they were able to access specialists when needed, such as, diabetic specialist nurses and podiatrists. At the short stay services, all staff were trained in physical health interventions which were required for their patient group. This included specialist training for health care assistants in interventions such as administering rectal diazepam for patients with severe epilepsy.
- Staff assessed patients nutritional and hydration needs as part of their initial assessment. The short stay services were meeting all their patients nutritional and hydration needs. Some patients required percutaneous endoscopic gastrostomy tube feeding (PEG feeding), whilst other patients required soft diet or liquids to be thickened. Staff were able to meet each individual dietary needs.
- Staff used Health of the Nation Outcomes Scales (HoNOS) to assess severity and outcome for patients. We saw copies of HoNOS rating scales in patient's files.
- Staff participated in clinical audits. Staff undertook weekly care plan and risk assessment audits as well as clinical environment audits. We reviewed these audits and saw that staff were completing these on a weekly basis.

Skilled staff to deliver care

- There was a full range of staff disciplines at the Agnes unit to support patients. These included health care assistants, nurses, social workers, occupational therapists, psychologists and doctors. At the short stay service, they had health care assistants and nurses. Patients attended day care centres during the day to access therapeutic activities.

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.

- Staff were experienced and had the relevant qualifications to their role. The trust offered staff specialist training for practice development. This included training in positive behaviour support and specialist physical health care interventions.
- Staff did not receive regular supervision. We reviewed the supervision log on the Agnes unit for the past six months and found the average rate of staff supervision was 32%. The lowest rates were in the month of June when only 10.5% of staff received supervision. The highest rate was October when 34% of staff were supervised. In the same period, short stay services staffs' average supervision rate was 61%. The lowest rate was 41% and the highest was 65%.
- Staff at the Agnes unit did not always receive an annual appraisal. We reviewed the appraisal records which showed that only 67% of staff had received an appraisal within the past year. However, 81% of staff at the short stay services had received an appraisal within the past year.
- Due to low levels of supervision and appraisal, senior staff could not identify issues with staffs' performance promptly and therefore they could not address these.
- Staff did not always receive training in the Mental Health Act and the Mental Health Act Code of Practice. Only 61% of staff had completed Mental Health Act training. However, staff we spoke with were able to demonstrate good knowledge of Mental Health Act and the guiding principles of the Code of Practice.
- Consent to treatment and capacity requirements were adhered to, and copies of consent to treatment forms were attached to medication charts where applicable. We checked the medication charts of 12 patients and found that all consent forms were attached to medication charts where appropriate.
- Patients had their rights under the Mental Health Act explained to them on admission. If patients understood their rights, staff repeated these on a monthly basis. However, if a patient did not understand their rights, there was no set timeframe for rights to be re-read. This could have a significant impact for patients on a Section 2 as it reduced the amount of time they would have to appeal this section.
- Mental Health Act administrators were available to provide legal advice on implementation of the Mental Health Act and its code of practice. Mental Health Act administrators oversaw detention paperwork to make sure it was complete. They completed regular audits to ensure staff applied the Mental Health Act correctly.

Multi-disciplinary and inter-agency team work

- There were monthly multidisciplinary team meetings which all staff attended. We reviewed the minutes of three meetings which all had standard agenda items such as team performance, recent incidents and lessons learned.
- There were good handovers within the team from shift to shift. We attended two handovers. Staff shared all relevant important information regarding patients and ward issues.
- There were good working relationships between the Agnes unit and the short stay services. There were also good relationships with community care coordinators, who regularly attended care reviews. There were effective working relationships with organisations outside of the trust such as social services and GPs.

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

Good practice in applying the Mental Capacity Act

- Patients had access to independent mental health advocates (IMHA). The trust used a local advocacy service. Contact details were on display around the wards and in the reception areas.
- Staff had received training in the Mental Capacity Act. The compliance rate for this training was 86%.
- In the six months between 1 March and 1 September there were 22 Deprivation of Liberty Safeguards (DoLS) applications. These were highest at Rubicon Close who had made nine applications.
- The trust had a policy on the Mental Capacity Act, including DoLS. Staff we spoke with were aware of the policy and could refer to this when asked.
- Staff were not adhering to the Mental Capacity Act Code of Practice. Patients with impaired capacity did not

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.

always have their consent assessed and recorded appropriately. At the short stay services, we found two patients who had not had a mental capacity assessment for consent to admission. Staff did not always complete capacity assessments on a decision specific basis. We found staff had completed capacity assessments for 3 patients, which stated the assessment was for all decisions and not decision specific.

- Staff we spoke with knew where to get advice regarding the Mental Capacity Act. Staff told us they would seek advice from senior staff, MHA administrators or management.
- Staff were not adhering to the principles of Mental Capacity Act. At the short stay services Deprivation of Liberty Safeguards applications were made at the start of every patient's admission, regardless of whether a mental capacity assessment had been completed. The Mental Capacity Act 2005 Code of Practice states "An assessment that a person lacks capacity must never be

based on their age, their appearance, assumptions about their condition, or any aspect of their behaviour." Staff were assuming patients lacked capacity due to their learning disability.

- Staff had not completed capacity assessments for consent to treatment until after they had applied for DoLS. The Deprivation of Liberty Safeguards Code of Practice states that "Managing authorities should have procedures in place that identifies: whether deprivation of liberty safeguards are necessary in a particular case, what steps they should take to assess whether to seek authorisation, and whether they had taken all practicable and reasonable steps to avoid a deprivation of liberty." Staff had not followed procedures to identify whether DoLS were necessary, and did not take all practicable and reasonable steps to avoid DoLS. This could lead to patients being deprived of their liberty unnecessarily.

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 treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs. We observed support given to patients at meal times. Staff treated patients with dignity and were caring. Staff interacted with patients at a level that was appropriate to individual needs.
- We spoke with 12 patients who told us that staff were very kind and caring.
- Patients told us that they felt safe on the wards and that staff were responsive to their needs.
- Staff understood the individual needs of patients. Staff were able to explain the needs of different patients and how they met the needs. We attended care programme approach meeting in which ward staff explained patients' individual needs to the multidisciplinary team. We also attended two handovers in which staff shared information on the needs of each patient.

The involvement of people in the care that they receive

- Patients are orientated to the ward upon admission. Staff showed patients around the ward and explain ward routines such as medication times and meal times. Staff gave patients information on ward activities.
- Staff actively involved patients in the planning of their care. We saw evidence that care plans included patient's views. Staff used a "my care plan" document to obtain patients views on their care. Upon admission, staff completed this with patients before sending it to carers to obtain their views and to complete any additional sections. We spoke with nine patients on the Agnes unit, five of which told us they had a copy of their care plan. Staff told us that patients did not always wish to have a copy of their care plan. However, staff had not documented that patients had refused a copy of their care plan in two care records that we reviewed.
- Patients had access to an advocacy service. Information on the advocacy service was displayed around the wards as well as in reception areas. We spoke with one patient who told us they had an advocate who helped them during their care reviews.
- Managers told us that carers were involved in interviewing staff. Staff told us that due to the severity of some their patient's learning disabilities it was difficult to involve them in decisions about the service.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- Beds were available when needed to people living in the catchment area. The average bed occupancy for the Agnes unit over the past six months was 55%. The average bed occupancy at the short stay services was 67%. One the Grange had the highest bed occupancy rates at 68% whereas the Agnes unit had the lowest bed occupancy rates at 52%. The average length of stay on The Agnes unit was 134 days and six days for the short stay services. The longest length of stay was 317 days.
- Staff did not use patient's beds whilst they were on leave from the wards.
- Staff did not move patients between wards during an admission unless it was justified on clinical grounds or for safeguarding patients. We found one incident where staff had moved a patient between pods at the Agnes unit. This was due to an incident of violence and aggression from another patient.
- Staff arranged patients discharge at an appropriate time of day. Staff told us they liaised with all appropriate people to plan discharge. Part of this plan was to arrange an appropriate time for discharge to happen. We reviewed the care records of a patient who staff were planning to discharge and saw evidence that staff had liaised with family and carers during care reviews to plan discharge.
- Beds were available in a PICU unit for male patients if required. Staff told us that they had to access this facility once in the past year. If a female patients needed a PICU bed this would have to be accessed out of area as there were no female PICU beds in the trust.
- Learning disabilities wards had recorded 11 delayed discharges in the year between August 2015 and July 2016. Staff told us the main reason for delayed discharge was due to difficulty in finding appropriate placements for patients in the community.

The facilities promote recovery, comfort, dignity and confidentiality

- The Agnes unit had a full range of rooms and equipment to support treatment and care. There was a separate area for patients to go to participate in therapeutic

- activities. Staff used various rooms for activities. These included a therapy kitchen, and a large room that staff could use for group activities. However due to limited space, the short stay services did not have sufficient rooms to support care and treatment. Apart from patients' bedrooms, there was limited space for staff to offer therapeutic one-to-one time with patients.
- The Agnes unit had quiet rooms on the wards where patients met visitors. There was a family room off the ward for patients to spend time with family. At the short stay services there were no separate quiet areas for patients to meet visitors apart from their bedrooms or the dining room.
- There was no access to a telephone for patients to make private phone calls at the Agnes unit. Patients could bring in mobile phones and use them in their bedroom for private phone calls. There was not a telephone available at the short stay services. However, staff facilitated phone calls by providing patients with the office cordless phone which they could use in their bedroom for privacy.
- The food at the Agnes unit was not of good quality. We spoke with nine patients who all described the food as disgusting and revolting. The trust brought food in prepacked and reheated it on the hospital site. We observed the mealtime at the Agnes unit. The food did not look appetising and portion sizes were small. However, the food at the short stay services was of good quality and was cooked fresh.
- Patients on all wards had access to hot drinks and snacks 24 hours a day. Patients asked staff at any time for snacks or a hot drink.
- Patients were able to personalise their bedrooms. We saw evidence that each ward with patients had bought personal items such as bed linen and posters in to personalise their bedroom.
- There is access to activities seven days a week at the Agnes unit. The occupational therapy team managed activities Monday to Friday and ward staff facilitated activities at weekends. At the short stay services, patients attended day care services Monday to Friday. However, there was limited access to activities at the

Are services responsive to people's needs?

Good 

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

weekends. There was a cupboard with some games and toys. Staff told us they would play board games with patients at the weekends or sometimes take them out for trips around the local area.

Meeting the needs of all people who use the service

- We spoke with four carers who felt that they were involved in their loved ones care. They were contacted and updated by staff and were invited to MDT meetings.
- Ward areas had made adjustments for people requiring disabled access. Wards were on the ground floor and had ramped access for wheelchairs. Internal and external doors were wide to allow easy access to someone in a wheelchair. At the short stay services, the garden areas were all accessible to someone in a wheelchair.
- Information leaflets were available in different languages for people whose first language was not English. Information leaflets were also available in easy read format. We saw evidence of some good easy read medication leaflets available at the Agnes unit.
- There was a variety of accessible information available. This included topics such as local services, patient rights and how to complain. This information was displayed around the wards and in the reception area. These were also available in different languages.
- Patients had access to interpreters and signers. Staff arranged for interpreters to attend clinical meetings where appropriate. We saw evidence in patients' records where this had happened.
- The Agnes unit food choice did not always meet the dietary requirements of patients. There was not always

a sufficient choice of food available. Staff planned meals two weeks in advance. We observed the mealtime at Agnes unit and saw there were two meal choices. However, there were only enough meals for the three patients on the ward. This meant that if a patient changed their minds, they would not have another choice. One patient told us they were vegan and that there was not always a choice suitable to their needs. On the day of inspection their meal was a vegetarian option rather than vegan. However, at the short stay services, patients were involved in planning the menu for the week. We saw evidence on the weekly meal plan that they were providing halal meat for Muslim patients.

Listening to and learning from concerns and complaints

- In the year between August 2015 and August 2016 the Agnes unit received two complaints and the short stay services received one. The trust upheld all of these complaints. There were no complaints referred to the ombudsman.
- Patients knew how to complain. Wards displayed information on how to make complaints. We spoke with 12 patients, nine of which said they knew how to complain.
- Staff were aware of how to manage complaints. Staff we spoke with knew the complaints process and were able to respond appropriately should someone make a complaint to them.
- Staff received feedback during team meetings on the outcomes of investigations into complaints. We reviewed team meeting minutes and saw that lessons learnt was a standard agenda item.

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

- Staff we spoke with were aware of the organisation's visions and values. Staff explained that trust, integrity, respect, and compassion underpinned the work they did on the ward.
- Staff were aware of who the senior managers in the organisation were. Staff told us that they occasionally visited the ward. Staff at the short stay services told us that the senior managers do an annual "Boardwalk" in which they visited all areas around the trust. They were due for their Boardwalk later that month.

Good governance

- The breach of the guidance on eliminating mixed sex accommodation had not been resolved and there were no plans in place.
- The food at the Agnes unit did not always meet the dietary and cultural needs of patients. The food was described as unappetising and, at times, "disgusting". The portions were small and this had been mentioned but no action taken to improve the food or portion size.
- Staff received mandatory training on an annual basis. Managers monitored staffs' compliance with mandatory training. At the Agnes unit the manager monitored mandatory training monthly. At the short stay services a mandatory training compliance spreadsheet was displayed in the staff office, so staff were aware of the expiry dates of training.
- Staff did not receive regular supervision or appraisals. The manager at the Agnes unit had only been in post for a month but was aware of the low supervision compliance. They were looking at methods to improve this which included looking at the activities programme and seeing how this could support ward staff to make time for supervision.
- The majority of shifts were covered by a sufficient number of staff of the right grade and experiences at the Agnes unit. They had a shift fill rate for qualified nurses of 160% for day shifts and 108% on night shifts. In spite of the high fill rate they did not always have a qualified nurse covering the nursing responsibilities for each pod. Staff told us that this would happen more often when

the fourth pod was open. On the day of inspection, there was one qualified member of staff covering pods three and four. The shift coordinator risk assessed the need and allocated staff dependent on where the need was greatest. At the short stay services they did not always have a qualified nurse on shift. The shift fill rate for day shifts on the short stay services was 71% for day shifts and 56% for night shifts. Staff told us that this would be dependent on the needs of the patients admitted at the time. The manager would look at the patient mix and allocate qualified nurses to shifts when they were required for care interventions that only qualified nurses could perform.

- Staff were able to maximise their time on direct care activities. During inspection, we observed staff engaging with patients throughout the day. Staff told us that they did not feel overwhelmed by paperwork and they spent a sufficient amount of time with patients.
- Staff participated in clinical audits. Staff had daily and weekly duties such as temperature monitoring of the clinic room, checking emergency equipment and doing care plan and risk assessment audits. Staff reported issues identified as part of audits. For example, in July and August 2016 staff reported seven incidents of high temperatures in the clinic room using the incident reporting system. We saw evidence that learning took place from staff reporting this.
- Managers did not ensure that staff followed procedures for implementing the Mental Capacity Act. We found incidents of capacity assessments for consent to admission had been completed two days after a patient had been admitted. We highlighted this to the manager who fed back to staff to make ensure staff completed these prior to admission.
- Staff followed Mental Health Act procedures. Mental Health Act administrators oversaw the monitoring of Mental Health Act compliance.
- Staff followed safeguarding procedures. The trust had a safeguarding team who were responsible for overseeing issues of safeguarding adults and children.
- The trust used key performance indicators (KPIs) to monitor the performance of teams. Ward staff told us that they had to meet a number of KPIs such as referral to admission times.

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.

Leadership, morale and staff engagement

- The sickness rate for the short stay services was 4.5% with one the Grange having the highest rates of 10%. This sickness in this core service was below the trust average of 5.1%. The sickness rate at the Agnes unit was 14.5% with pod one having the highest rates of 28.5%. This was above the trust average sickness rate.
- There were no cases of bullying and harassment within the learning disability wards.
- Staff told us they knew how to use the whistleblowing process. There was information displayed in staff offices regarding whistleblowing with contact details of who to call. Staff told us that they felt they would be able to raise concerns without fear of any victimisation.
- There was good staff morale and job satisfaction. Staff we spoke with told us they enjoyed working on the wards and felt there was good support from their peers. Staff felt that teams worked well together and supported each other.
- There were opportunities for leadership development. The manager of the short stay services told us that they had just completed some leadership training.
- Staff were open and transparent and explained to patients when things went wrong. Staff we spoke with were able to explain their duty of candour. We saw evidence in incident reports that staff had informed patients when staff had made a mistake for example, medication errors.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

The short stay services did not comply with the mixed sex accommodation guidelines. There were no separate areas for female bedrooms. There were no separate male and female bathrooms and toilets.

This is a breach of regulation 10.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Staff were assessing for capacity to consent to admission after admission had taken place and after they had made a DoLS application. Capacity assessments were not decision specific.

This was a breach of regulation 11.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Staff did not receive regular supervision in line with the trust policy.

This is a breach of regulation 18.