

Coveberry Limited

Oldbury Birmingham

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Insufficient evidence to rate



Are services caring?

Good



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: Model of Care and setting that maximises people's choice, control and independence

- The service strived to support people to have the maximum possible choice, control, and independence, be independent and they had control over their own lives.
- Staff focused on people's strengths and promoted what they could do, so people had a fulfilling and meaningful everyday life.
- People were supported by staff to pursue their interests.
- Staff supported people to achieve their aspirations and goals.
- The service worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative.
- Staff did everything they could to avoid restraining people. The service recorded when staff restrained people. However, we did not see evidence in staff meetings about learning from incidents.
- People had a choice about their living environment and were able to personalise their rooms.
- People benefitted from the interactive and stimulating environment
- The service made reasonable adjustments for people so they could be fully in discussions about how they received support, including support to travel wherever they needed to go.
- Staff supported people to play an active role in maintaining their own health and wellbeing.
- Staff supported people to take part in activities and pursue their interests in their local area.
- Staff enabled people to access specialist health and social care support in the community.
- Staff supported people to make decisions following best practice in decision making but this was limited due to the longstanding speech and language therapy vacancy which reduced peoples confidence and ability to speak up for themselves.
- Staff supported people with their medicines in a way that promoted their independence and achieved the best possible health outcome.

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights

- Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care.
- Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs.
- Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Although staff had training available on how to recognise and report abuse there were low completion rates.
- People's care, treatment and support plans reflected their range of needs and this promoted their wellbeing and enjoyment of life.
- People received care that supported their needs and aspirations, was focused on their quality of life, and followed best practice.

Summary of findings

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

- People received good quality care, support, and treatment because trained staff and specialists could meet their needs and wishes.
- People were supported by staff who understood best practice in relation to the wide range of strengths, impairments, or sensitivities people with a learning disability and/or autistic people may have. This meant people received compassionate and empowering care that was tailored to their needs.
- Staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing.
- Staff placed people's wishes, needs, and rights at the heart of everything they did.
- People and those important to them, including advocates, were involved in planning their care.
- Staff evaluated the quality of support provided to people, involving the person, their families, and other professionals as appropriate.
- The service enabled people and those important to them to work with staff to develop the service. Staff valued and acted upon people's views.
- People's quality of life was enhanced by the service's culture of improvement and inclusivity.
- Staff ensured risks of a closed culture were minimised so that people received support based on transparency, respect, and inclusivity.
- However, the poor quality of the ward environment meant care provided was not always dignified. For example, when people had to use old or dirty furniture.

SUMMARY

Our rating of this service went down. We rated it as requires improvement because:

- People were protected from abuse and poor care. The service had enough, appropriately skilled staff to meet people's needs and keep them safe.
- People were supported to be independent and had control over their own lives. Their human rights were upheld.
- People received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood.
- People's risks were assessed regularly and managed safely. People were involved in managing their own risks whenever possible.
- If restrictive practices were used, there was a reporting system in place and there were comprehensive reviews to try and reduce the use of these practices.
- People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- People's care, treatment, and support plans reflected their sensory, cognitive, and functioning needs.
- People received care, support and treatment that met their needs and aspirations. Care focused on people's quality of life and followed best practice. Staff used clinical and quality audits to evaluate the quality of care.
- The service provided care, support and treatment from trained staff and specialists able to meet people's needs. Managers ensured that staff had relevant training, regular supervision, and appraisal.
- People and those important to them, including advocates, were actively involved in planning their care. A multidisciplinary team worked well together to provide the planned care.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983, and the Mental Capacity Act 2005.

Summary of findings

- People were in hospital to receive active, goal oriented treatment. People had clear plans in place to support them to return home or move to a community setting. Staff worked well with services that provide aftercare to ensure people received the right care and support they went home.
- Staff supported people through recognised models of care and treatment for people with a learning disability or autistic people. Leadership was good, and governance processes helped the service to keep people safe, protect their human rights and provide good care, support, and treatment.

However,

- People were cared for in an environment that was not always clean and in which some of the furnishings were damaged. We found that a fridge and cupboards where food was stored were dirty and the covering on some chairs was ripped.
- Although the provider had a decorator on site decorating the environment, and they organised more furniture to be delivered during this inspection. However, some of this replacement furniture was dirty.
- There were blind spots on the ward that were not mitigated with mirrors or CCTV. We saw that one of the mirrors staff had put up to try to mitigate a blind spot was not fully fixed to the wall and could be easily removed.
- Some training completion rates were low. Training rates basic life support was 60% and the highest training completion rate for the providers restraint training modules which was 61%.
- Some staff told us they did not always feel valued or supported by managers and that this contributed to them feeling stressed at work.
- The service did not operate regular team meetings. Some staff told us they rarely had team meetings and minutes of meetings provided to us showed these had happened every 4 months.

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



Summary of findings

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Summary of this inspection

Background to Oldbury Birmingham

Oldbury Birmingham is a 15 bed specialist inpatient service for men aged 18 and upwards, who have mental health issues and a learning disability or autism. Some people may be detained under the Mental Health Act (MHA) and some may have complex needs that are not being met in their current placement. Some people were detained under the MHA with conditions from the Ministry of Justice. At the time of this inspection there were 12 people at the service, and all were detained under the MHA.

At the time of our inspection, a registered manager was in place.

Oldbury Birmingham is registered with the CQC to carry out the following regulated activities:

- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act.
- Diagnostic and screening procedures.

Since our last inspection, the provider has changed. Oldbury Birmingham was previously inspected by the CQC in June 2017 (inspection report published 28 July 2017). This is our first inspection since the location was registered to a new provider, Coveberry Limited.

What people who use the service say

We spoke with six people who lived at the hospital. Four people either preferred or were comfortable to speak with us by themselves, and two people asked a member of staff to support them, saying that they were supportive. All six people were able to converse with us without the use of communication aids.

Five out of six people told us they came from the West Midlands and most were local to Birmingham and the Black County. All spoke of being discharged back to their local area and could name the areas they wished to live. One person did not like being so far away from his family and would either like to return to his home area or stay locally. Two out of six people said they did not know their discharge plan and one said they did not have a date. Although one person who did not know their discharge plan, they spoke of speaking with staff about moving to a residential placement. Three people were able to describe their plans to us. All spoke of staff from community services in supporting them.

All people said the food was of a good quality and they had the choice of making their own meals. All said they could take leave into the community and did not say it was ever cancelled. They talked about a variety of activities on offer, both in the hospital and the community, including going to a community college and staff supporting them to access a job they wanted to do with animals. However, one person said they got bored at weekends. All were able to personalise their room with items they liked, including family pictures. People said staff supported and encouraged them with their pastimes, including time spent in the community. However, one person said staff had told him that his possessions were 'clutter' and needed to be tidied up.

People said the hospital was generally clean and tidy however, one person said their room needed decorating but were aware the whole hospital was being decorated. They also described some damage to the walls that needed to be repaired. They agreed we could take photos of the damage.

Summary of this inspection

People described having access to external physical healthcare and using services including a GP, dentist, and optician. All said their physical healthcare was looked after and one person described how staff had supported them to overcome their fears of physical interventions and had been able to have their blood pressure taken and receive their COVID-19 vaccination and boosters.

All people knew the new manager and were able to raise concerns freely. All knew who the members of the multidisciplinary team were and said they were visible. All people had an idea of what they needed to do to move back into the community and treatment supported this. One person was able to describe in detail how they had improved the way they were able to manage their distress, not get upset with other people and how incidents had reduced where he is near ready for discharge back to his previous placement.

However, two people used the term “being bullied” at the hospital and one said staff had an attitude. All were verbal interactions with staff. One person felt that staff were wrong not to restrain another person after they assaulted a member of staff, saying they should not have been allowed to carry on walking around the area while staff observed. They also said they do not like new staff starters who have to shadow experienced staff when learning to observe him. He said staff told him that they have to do it and he did not like the way he was spoken to. However, he felt safe at the service. Another person described bullying and not being treated well by staff, referring to the way he was spoke to. Another person said staff picked on him when he was minding his own business, saying that when other people who use the service get upset, staff try and bring him into the argument, and he does not like it. But, all three were able to describe that staff, including the hospital also treated them with kindness. The other three people said that staff always treated them with kindness and respect. They described being treated with dignity and told us staff were approachable. They were able to describe positive experiences and activities with staff.

How we carried out this inspection

We were on site for three days and one evening. Our inspection team comprised of three Inspectors and two Inspection Managers.

During the inspection

- We spoke to six people with a learning disability or autism about their experience of the care provided.
- We reviewed a selection of CCTV footage.
- We reviewed the environment of the ward, including the outdoor space.
- We spoke to nine staff including support workers, the psychologist, and the ward manager
- We reviewed nine care records and six medicines charts
- We received feedback from the host commissioners of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of this inspection

Action the service **MUST** take to improve:

We told the service that it must take action to bring services into line with legal requirements.

- The service must ensure that the environment is clear of clutter that would present a fire risk. Regulation 12 (1)(2)(a)(b)(d)
- The service must ensure that there is adequate mitigation of all blind spots in communal areas. Regulation 12 (1)(2)(a)(b)(d)
- The service must ensure that staff are up to date on mandatory training. Regulation 12 (1)(2)(c)
- The service must ensure that all relevant staff are trained in immediate life support training. Regulation 12 (1)(2)(c)
- The service must ensure that the ward is kept clean. Regulation 15 (1)(a)
- The service must ensure audits are regularly undertaken in order to identify gaps in service provision and where improvements could be made. Regulation 17 (1) (2) (a)

Action the service **SHOULD** take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure that proactive steps are taken to recruit to the speech and language therapy vacancy.
- The service should ensure learning from incidents and complaints is shared across the whole staff team.
- The service should ensure people's care and treatment plans reflect what is needed to support their discharge pathway.
- The service should consider implementing regular nursing team meetings and supporting staff to attend these.






Our findings

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	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement	Requires Improvement

Wards for people with learning disabilities or autism

Safe	Requires Improvement 
Effective	Insufficient evidence to rate 
Caring	Good 
Responsive	Requires Improvement 
Well-led	Requires Improvement 

Is the service safe?

Requires Improvement 

Safe and clean care environments

People were cared for in an environment that was not always clean and in which some of the furnishings were damaged. We found that a fridge and cupboards where food was stored were dirty and the covering on some chairs was ripped. The provider had a decorator on site decorating the environment, and they organised more furniture to be delivered during this inspection because of inspector feedback. However, some of this replacement furniture was dirty as it was brought in from another service

People were cared for in wards where staff had completed risk assessments of the environment for ligature. However, there were five blind spots on the ward that were not mitigated with mirrors or CCTV. This meant that staff could not easily review incidents using CCTV for all communal areas. We saw that one of the mirrors staff had put up to try to mitigate a blind spot was not fully fixed to the wall and could be easily removed. Staff were positioned in spots around the unit to be able to safely observe patients.

In addition, we found that the provider had not included the risk of fire to their site risk register. The fire doors were also blocked by clutter. Following the inspection, the provider had updated their risk assessment form to include the risk of arson and accidental fire. The provider had also removed any clutter blocking the fire doors and redecoration was in progress. We found, in one cupboard, a fire extinguisher out of date. The service explained this was an oversight as all extinguishers had been checked. This was reported on the day of the inspection with remedial action taken to get it checked.

People had easy access to nurse call systems and staff had easy access to alarms.

There was no seclusion room and staff said they did not seclude people.

The service prevented visitors from catching and spreading infections. Staff used personal protective equipment (PPE) effectively and safely. The service followed shielding and social distancing rules. The service tested for infection in people using the service and staff.

Wards for people with learning disabilities or autism

The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing. The service's infection prevention and control policy was up to date.

The service could support visits for people in line with current guidance. This included safe visiting protocols during the COVID-19 pandemic.

Safe staffing

The service had enough nursing and medical staff, who knew the people and received basic training to keep people safe from avoidable harm.

The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted. People who used the service told us of access to activities and how staff supported them.

The numbers and skills of staff matched the needs of people using the service. Staff recruitment and induction training processes promoted safety.

Staff knew how to take into account people's individual needs, wishes and goals.

Every person's record contained a clear one-page profile with essential information so that new or temporary staff could see quickly how best to support them.

Managers made sure bank and agency staff had an induction and understood people's needs before starting their shift. For example, they could complete shadow shifts before starting work on the ward and there was an induction booklet for agency and bank staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and health care assistants for each shift. The ward manager could adjust staffing levels according to people's needs.

People had regular one-to-one sessions with their named nurse. Staff audited this to ensure that people did not miss sessions with their named nurse.

People rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep people safe when handing over their care to others.

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency.

The training programme was comprehensive and met the needs of people and staff. However, not all staff had completed their mandatory training requirements prior to starting work on the ward. For example, we found that the following courses had compliance rates below 75%: Basic Life Support, management of violence and aggression, health and safety, and personal safety training. After the completion of the report, the provider sent local training records that highlighted violence and personal safety training at 91% and Basic Life Support at 87%.

Wards for people with learning disabilities or autism

Information given to us on inspection indicated training rates were low for basic life support (BLS) and the provider's restraint training. BLS was reported to have a completion rate of 60% and the restraint training had a reported completion rate of 61%. We did not receive training figures for immediate life support training (ILS) at the time of the inspection.

However, minutes of clinical government meetings indicated the provider had planned training days for immediate life support in June and September 2022. Following this inspection, we did receive information regarding appropriate staff attending immediate life support training and those appropriate to do so had figures of 100%. However, we also received signing in sheets for staff attending intermediate life support training but there were no signatures and no assurance they had completed the training. Intermediate and immediate life training are two different life support training and aimed at different staff. We were therefore not assured of which figures to take into account and what the actual figures were for those who were trained.

Assessing and managing risk to patients and staff

People lived safely and free from unwarranted restrictions because the service assessed, monitored and managed safety well.

People were involved in managing risks to themselves and in taking decisions about how to keep safe. We saw this reflected in the nine care records we reviewed.

People, including those unable to make decisions for themselves, had as much freedom, choice, and control over their lives as possible because staff managed risks to minimise restrictions.

People's care records helped them get the support they needed because it was easy for staff to access and keep high quality clinical and care records. Staff kept accurate, complete, legible, and up-to-date records, and stored them securely.

The service helped keep people safe through formal and informal sharing of information about risks. We saw that informal risk information was discussed in handovers as well as formal information sharing about risks.

Staff managed the safety of the living environment and equipment in it well through checks and action to minimise risk.

People's freedom was restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible. For example, people would not be searched on their return to work unless there was an individual need for this to happen and it would be documented in the person's care plan.

Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe.

Staff considered less restrictive options before limiting people's freedom. Staff were able to describe how they would de-escalate situations.

Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom.

Staff restricted people's freedom based only on their individual needs. Staff made every attempt to avoid restraining people and did so only when de-escalation techniques had failed and when necessary to keep the person or others safe. If a person's freedom was restricted by staff, they received emotional support when needed.

Wards for people with learning disabilities or autism

People were restrained only where evidence demonstrated it was necessary, lawfully justified, used for the minimum period of time, had a justifiable aim, and was in the person's best interest, and that it was used in a safe and proportionate way.

All restrictions of people's freedom were documented, monitored and triggered a review of the person's support plan. We saw this in the care records we reviewed.

Staff knew about any risks to each person and prevented or reduced risks.

Staff identified and responded to any changes in risks to people or posed by them.

Where staff were trained in the use of restrictive interventions, the training was certified as complying with the Restraint Reduction Network Training standards

If staff restricted a person's freedom, they took part in post incident reviews and considered what could be done to avoid the need for its use in similar circumstances

People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

People and those who matter to them had safeguarding information in a form they could use, and they knew how and when to raise a safeguarding concern.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Family visits were held in a separate room with a protocol to follow to keep children safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – both paper-based and electronic.

Medicines management

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism, or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.

People received support from staff to make their own decisions about medicines wherever possible.

People could take their medicines in private when appropriate and safe.

Staff made sure people received information about medicines in a way they could understand.

Wards for people with learning disabilities or autism

Staff followed effective processes to assess and provide the support people needed to take their medicines safely. This included where there were difficulties in communicating, when medicines were given covertly, and when assessing risks of people taking medicines themselves.

Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines. We saw this in the nine care records we reviewed.

Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services.

Staff reviewed the effects of each people's medication on their physical health according to The National Institute for Health and Care Excellence (NICE) guidance. This included physical health checks where a person was prescribed antipsychotic medicines.

People received their medicines from staff who prescribed, administered, recorded, and stored their medicines safely.

Track record on safety

People received safe care because staff learned from safety alerts and incidents.

The service managed incidents affecting people's safety well. Incident analysis reports were produced monthly and these included outcomes and lessons learnt as well identifying themes and trends.

Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned. Staff were able to talk us through their use of de-escalation with a person who had tested positive for COVID-19 and talk us through how they reduced the person's distress.

When things went wrong, staff apologised and gave people honest information and suitable support.

Staff raised concerns and recorded incidents and near misses and this helped keep people safe. For example, we saw evidence of incidents being discussed in staff meetings to share learning.

The service recorded any use of restrictions on people's freedom, and managers reviewed use of restrictions to look for ways to reduce them.

Managers and staff were aware of the Learning from Deaths Mortality Review (LeDeR) Programme. They supported the review process and made changes from any learning shared.

Is the service effective?

Insufficient evidence to rate 

Not enough evidence to rate

Wards for people with learning disabilities or autism

Assessment of needs and planning of care

Staff completed a comprehensive assessment of each person's physical and mental health either on admission or soon after. We reviewed nine care records and saw this was the case.

People had care and support plans that were personalised, holistic, strengths-based and reflected their needs and aspirations, including physical and mental health needs. People, those important to them and staff reviewed plans regularly together.

Care plans reflected a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs. Staff ensured people had up-to-date care and support assessments, including medical, psychological, functional, communication, preferences, and skills.

Support plans set out current needs, promoted strategies to enhance independence, and demonstrated evidence of planning and consideration of the longer-term aspirations of each person.

There were clear pathways to future goals and aspirations, including skills teaching in people's support plans. However, not all people were able to tell use their discharge plans or had a date for discharge.

Best practice in treatment and care

Staff supported people with their physical health and encouraged them to live healthier lives. This included access to psychological therapies, support for self-care and the development of everyday living skills. Staff recorded how often people accessed psychological therapies in their notes.

People were supported by staff who understood best practice in relation to the wide range of strengths, impairments, or sensitivities people with a learning disability and/or autistic people may have. This meant people received compassionate and empowering care that was tailored to their needs.

Staff understood people's positive behavioural support plans if they had them and provided the identified care and support.

Staff made sure people had access to physical health care, including specialists as required. For example, making dental appointments and access to specialist care for diabetes.

Staff met people's dietary needs and assessed those needing specialist care for nutrition and hydration. For example, monitoring people's food and fluid intake, when needed.

However, the service did not have a dedicated speech and language therapist (SALT) although they had tried to recruit. The vacancy was for one day per week and had been open for 18 months at the time of the inspection. Managers told us that if people needed to, they could access community SALT.

Skilled staff to deliver care

People received good care as managers supported staff through regular, constructive clinical supervision of their work. Staff audited their supervision to make sure that it was completed.

Staff could describe how their training and personal development related to the people they supported. For example, giving people time and space to communicate their needs properly and adopting their tone of voice to be clear and calm when speaking to people.

Wards for people with learning disabilities or autism

If people were assessed to lack capacity to make certain decisions for themselves or had fluctuating capacity, staff made decisions on their behalf which were in their best interests. This was supported by effective staff training and supervision.

People benefitted from reasonable adjustments to their care to meet their needs, and their rights were respected. This was because staff put their learning into practice.

If staff had to restrict people's freedom teams held debriefing meetings and reflected on their practice to consider improvements in care.

Staff were knowledgeable about and committed to using techniques which reduced the restriction of people's freedom.

Staff received support in the form of continual supervision, appraisal, and recognition of good practice. Staff supervision was at 88% in June 2022.

However, the service did not offer group supervision or reflective practice sessions for staff which was a missed opportunity to improve practice.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care.

However, the service had a vacancy for an occupational therapist and a speech and language therapist. Speech and language therapists assess people's individual speech, language, and communication in order to plan care and treatment that supports confidence in interacting with others, builds independence, and supports progression back into the community.

The ward team had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge.

People had health action plans or health hospital passports that enabled health and social care services to support them in the way they needed.

Multidisciplinary team professionals were involved in or made aware of support plans to improve care. For example, people we spoke to told us they knew who their social workers were.

Staff shared clear information about people and any changes in their care, including during handover meetings.

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

Staff understood their roles and responsibilities and were able to explain people's rights to them.

People had easy access to information about independent mental health advocacy, and people who lacked capacity to make decisions for themselves were automatically referred to the service. Completion rates for staff training on the Mental Health Act were 91%.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the people's notes each time.

Wards for people with learning disabilities or autism

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed.

Care plans included information about after-care services available for those people who qualified for it under section 117 of the Mental Health Act.

Staff ensured people had an Independent Mental Health Advocate or were offered one as needed.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They assessed and recorded capacity clearly for people who might lack the mental capacity to make certain decisions for themselves. Eighty one per cent of staff had completed training on the Mental Capacity Act.

Staff empowered people to make their own decisions about their care and support and obtained people's consent in an inclusive way. For example, people were provided with information in easy-read or pictorial format to support their ability to understand their care and treatment.

Staff ensured that an Independent Mental Capacity Advocate was available to help people if they lacked capacity to make decisions for themselves and they had nobody else to represent their interests.

For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any decisions made on their behalf in their best interests.

Staff gave people all possible support to make specific decisions for themselves before deciding they did not have the capacity to do so.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Most staff treated people with compassion and kindness and respected people's privacy and dignity. They understood people's individual needs of and supported them to understand and manage their care, treatment, or condition.

People received kind and compassionate care from most staff who mostly used positive, respectful language at a level people understood and responded well to. However, three out of six of the people we spoke with said there were problems with staff attitude. Two people said that they felt bullied at times.

Wards for people with learning disabilities or autism

We observed staff being patient with people. They were calm, focused, and attentive to people's emotional and other support needs and sensory sensitivities.

People felt valued by staff who showed genuine interest in their well-being and quality of life. Staff showed warmth and respect when interacting with people. For example, we saw evidence of staff proactively supporting people and making sure they had opportunities to engage in their areas of interest.

People had the opportunity to try new experiences, develop new skills and gain independence.

Each person had a support plan that identified target goals and aspirations and supported them to achieve greater independence including skills development.

People's rights were upheld by staff who supported them to be independent and have control over their own lives.

Staff knew when people needed their space and privacy and respected this.

Staff supported people to understand and manage their own care treatment or condition. For example, people had copies of their care plans in easy read formats and they understood what the plan was for their care and treatment.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards people.

Staff followed the policy to keep people's information confidential.

Involvement in care

Staff involved people in care planning and risk assessment and sought their feedback on the quality of care provided.

People told us that they had easy access to independent advocates.

People were listened to, given time, and supported by staff to express their views using their preferred method of communication.

Staff took the time to understand and develop a rapport with people.

People were enabled to make choices for themselves. Staff ensured they had the information they needed.

Staff respected people's choices and wherever possible, accommodated their wishes, including those relevant to protected characteristics – for example, due to cultural or religious preferences.

People were supported to access independent, good quality advocacy.

People were empowered to make decisions about the service when appropriate and felt confident to feed back on their care and support.

People and those important to them took part in making decisions and planning their care and in risk assessments.

Wards for people with learning disabilities or autism

People felt listened to and valued by staff who engaged meaningfully with them.

Staff supported people to maintain links with those important to them.

Staff introduced people to the ward and the services as part of their admission. Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication needs).

Staff informed and involved families and carers appropriately where they were involved. Staff helped families to give feedback on the service. However, not all people who lived at the service had family contact and those that did, were not always visited.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Discharge was not always planned and managed well. Although staff liaised with services that would provide aftercare, the MDT (Multidisciplinary team) was not always assertive in managing the discharge care pathway. For example, although we saw evidence of discharge planning in people's Care Planning Approach (CPA, a framework to assess needs and then plan, implement and evaluate people's care and treatment) this was not reflected in some people's day to day activity plans.

Due to the complexities of some of the people's risks and detention under the Mental Health Act it was difficult to find community placements for people to move on to. We spoke with staff and commissioners who confirmed this was the case.

However, some people had been at the service for a long time, including one person who had been there for 13 years. Although we found evidence of discharge planning in care records, people's activity plans were not always focussed on increasing independence and moving on from the service. There was also no clear focus on discharge in the MDT meeting.

The provider complied with the care and treatment (education) reviews for people who lived at the service.

If a person was not from the local area staff supported them, in line with their wishes, to have regular contact with family, friends or an advocate

When people went on leave there was always a bed available when they returned.

Staff did not move or discharge people at night or very early in the morning.

Staff planned some people's discharge and worked with care managers and coordinators to make sure this went well. However, in some care records we looked at, people's discharge pathway was not fully reflected in their care plans or day to day work which meant they might be kept in hospital longer than necessary.

Wards for people with learning disabilities or autism

Staff supported people when they were transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support people's treatment, privacy, and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.

There were quiet areas for privacy. The food was of good quality and people could make hot drinks and snacks at any time.

The service had quiet areas and a room where people could meet visitors in private.

People could make phone calls in private.

The service had an outside space that people could access easily.

However, there was with a lack of storage on the unit. People's belongings were piled on the floor which led to a fire risk and did not promote dignity for people. We raised this with the service at the time of the inspection and they told us that they had ordered more storage furniture.

Some bedrooms needed to be decorated. Although there was a decorator starting this work progress was slow as they were responsible for the whole hospital.

We observed staff bringing a chair from another ward for use in one person's bedroom. However, this chair did not look clean.

Patients' engagement with the wider community

The service was in a community which had access to some shops and staff supported people with family relationships and community activities outside the service, such as work and education.

Staff supported people to take part in their chosen social and leisure activities on a regular basis. Staff gave people person-centred support with self-care and everyday living skills.

Staff ensured adjustments were made so that people could take part in activities.

Staff were committed to encouraging people, in line with their wishes, to explore new social, leisure and community-based activities.

Meeting the needs of all people who use the service

Staff discussed ways of ensuring targets for people were meaningful. They spent time with people understanding how they could be achieved.

Staff provided effective skills teaching because it was tailored to individual people. People learned everyday living skills, understood the importance of personal care, and developed new interests by following individualised learning programmes with staff who knew them well.

Staff offered choices tailored to individual people using a communication method appropriate to that person.

Wards for people with learning disabilities or autism

However, the provider did not have a SALT in the multidisciplinary team. We were concerned this meant that people could not be supported to confidently communicate to the best of their ability and care plans could not be fully tailored to people's individual needs.

Staff ensured people had access to information in appropriate formats, which included easy read, using photographs and symbols. For example, we saw an easy read version of the provider's statement of purpose and a service user guide for new admissions.

Staff provided information using objects/photographs/ gestures/symbols/other visual cues to help people know what was going to happen during the day and who would be supporting them.

People had individual communication plans/ passports that detailed effective and preferred methods of communication, including the approach to use for different situations.

Staff had good awareness, skills and understanding of people's individual communication needs. They knew how to facilitate communication and when people were trying to tell them something.

People received individualised support such as tailored visual schedules to support their understanding.

Staff made sure people could access information on treatment, local services, their rights and how to complain.

Listening to and learning from concerns and complaints

People and those important to them could raise concerns and complaints easily, and staff supported them to do so. However, people told us that they could speak with the manager of the service and some permanent staff, whom they said they trusted, but not with agency or back staff.

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them.

People knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in areas used by people.

Managers shared feedback from complaints with staff, and learning was used to improve the service. We saw examples where complaints about door banging had led to staff being reminded in daily handovers as well as posters being put up around the unit to remind staff to close doors quietly.

Is the service well-led?

Our rating of well-led went down. We rated it as requires improvement.

Wards for people with learning disabilities or autism

Leadership

Leaders had the skills, knowledge, and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. Management and staff put people's needs and wishes at the heart of everything they did.

Leaders worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights, and enabled them to develop and flourish.

Vision and strategy

The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible.

However, most of the staff we spoke to were unsure of the provider's vision and could not describe it.

Culture

Most staff we spoke to said they felt respected, supported, and valued. They said the service provided opportunities for development and career progression and that they could raise any concerns without fear.

However, some staff told us they did not always feel valued or supported by managers and that this contributed to them feeling stressed at work.

However, the service did not operate regular team meetings for staff. Some staff told us they rarely had team meetings and minutes of meetings provided to us showed these had happened every 4 months.

Governance

Governance processes were not always effective and did not always help to hold staff to account, keep people safe, protect their rights and provide good quality care and support.

For example, although staff used some recognised audit and improvement tools, which resulted in good outcomes in some areas. For example, incident data was analysed, and a monthly report produced which identified themes and learning. However, audits had not identified the risks of blind spots, the cleanliness of the ward or the low mandatory training rates for basic life support and management of violence and aggression training.

The management of records and recordings of surveillance ensured they were protected and stored safely.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed.

Staff were able to explain their role in respect of individual people without having to refer to documentation. They gave good quality support consistently.

Staff acted in line with best practice, policies, and procedures.

Wards for people with learning disabilities or autism

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well, and helped to improve the quality of care.

Information governance systems included confidentiality of patient records and referenced the General Data Protection Regulation (GDPR).

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Staff made notifications to external bodies as needed. This included statutory notifications to the Care Quality Commission.

Engagement

People and those important to them worked with managers and staff to develop and improve the service.

Staff encouraged people to be involved in the development of the service, but this was limited to community meetings on the ward, which were not always well attended.

The provider sought feedback from people and those important to them and used the feedback to develop the service.

The service worked well in partnership with advocacy organisations/ other health and social care organisations, which helped to give people using the service a voice/ improve their health and life outcomes.

Learning, continuous improvement and innovation

Staff collected and analysed data about outcomes and performance and engaged in local and national quality improvement activities. For example, the provider engaged with the national audit for stopping over medication of people with a learning disability, autism, or both with psychotropic medicines (STOMP).

However, we did not see evidence of learning from incidents discussed in the minutes of staff meetings we reviewed.

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 Diagnostic and screening procedures	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose <ul style="list-style-type: none">• The service must ensure that the environment is clear of clutter that would present a fire risk. Regulation 12 (1)(2)(a)(b)(d)• The service must ensure that there is adequate mitigation of blind spots in communal areas. Regulation 12 (1)(2)(a)(b)(d)• The service must ensure that staff are up to date on mandatory training. Regulation 12 (1)(2)(c)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment <ul style="list-style-type: none">• The service must ensure that the ward is kept clean. Regulation 15 (1)(a)
Regulated activity	Regulation
Diagnostic and screening procedures Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance <ul style="list-style-type: none">• The service must ensure audits are regularly undertaken in order to identify gaps in service provision and where improvements could be made. Regulation 17 (1) (2) (a)