

**Requires Improvement**

# Nottinghamshire Healthcare NHS Trust

## Services for people with learning disabilities or autism

### Quality Report

RHA

Tel: 0115 969 1300

Website: [www.nottinghamshirehealthcare.nhs.uk](http://www.nottinghamshirehealthcare.nhs.uk)

Date of inspection visit: 29 April - 2 May 2014

Date of publication: 31/07/2014

#### Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Highbury Hospital	RHANM	Orion Unit	NG6 9DR
Mansfield Community Hospital	RHABL	Alexander House	NG18 5QJ
Highbury Hospital	RHANM	Hucknall House	NG6 9DR
Duncan MacMillan House	RHA	Community Intellectual and Developmental Disabilities Teams	NG3 6AA

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare 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 Nottinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare 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 Services for people with learning disabilities or autism

Requires Improvement



Are Services for people with learning disabilities or autism safe?

Requires Improvement



Are Services for people with learning disabilities or autism caring?

Good



Are Services for people with learning disabilities or autism effective?

Requires Improvement



Are Services for people with learning disabilities or autism responsive?

Good



Are Services for people with learning disabilities or autism 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

## Contents

### Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Background to the service	7
Our inspection team	7
Why we carried out this inspection	7
How we carried out this inspection	7
What people who use the provider's services say	8
Good practice	8
Areas for improvement	9

---

### Detailed findings from this inspection

Locations inspected	10
Mental Health Act responsibilities	10
Mental Capacity Act and Deprivation of Liberty Safeguards	10
Findings by our five questions	12
Action we have told the provider to take	28

---

# Summary of findings

## Overall summary

Nottinghamshire Healthcare NHS Trust provides a range of inpatient and community services for people who have a learning disability or autism. These include the Orion Unit assessment and treatment service, Alexander House locked rehabilitation service, Hucknall House short break respite service, and a range of community teams.

We found that staff across the services were caring and compassionate. They worked positively with people and supported them well. In the Orion Unit, we were concerned that one person was segregated on a long-term basis, but their records did not show the reasons for this or how staff could ensure their safety and wellbeing. In addition, there were no plans in place to show staff how to support people who use the service when they became aggressive, and in turn ensure their safety and that of others. The physical health of people who used the services was also not monitored and recorded.

Alexander House had a good range of activities and used community services. However, activities and community services were limited in the Orion Unit and Hucknall House.

In all services, professionals worked together to meet the needs of people who used the services.

We saw examples of good and innovative practice being used in community services, but psychological services did not have a link to the trust board. This could mean that they were not used or given a high enough profile that would benefit people who used the service.

Staff, particularly in inpatient services, felt that learning disability and autism services were not involved and were the forgotten link in the trust.

Each inpatient service worked on their own and did not share good practice with other inpatient services.

# Summary of findings

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

### Are services safe?

Some of the practices used in inpatient services were restrictive and could put people at risk of harm. In addition, risks were not always fully assessed to ensure that staff knew how to safely support everyone who used the service.

Staff received training in how to protect people from harm and demonstrated that they knew how to do this. They were also given training in managing violence and aggression.

Requires Improvement



### Are services effective?

The physical health needs of people who used the service were not monitored to ensure their health and wellbeing.

Staff received the training they needed to meet the needs of people who used the service.

The environment in Alexander House and in Hucknall House was institutional, which did not make people feel comfortable and allow them to relax.

Staff from all professions worked together to meet the needs of people who used the service.

The Orion Unit and Hucknall House did not offer a range of activities.

Requires Improvement



### Are services caring?

Staff were caring and compassionate to the people who used the service.

Staff were genuinely motivated to support people in their recovery and to help them rehabilitate in the community.

People who used the service were treated with dignity and respect.

People's capacity was assessed and where people lacked the mental capacity to make decisions about their care and treatment, decisions were made in their best interests.

Good



### Are services responsive to people's needs?

Community services were flexible to meet people's needs and suit their preferences.

Community teams worked with inpatient services to ensure people's needs were met.

The religious and cultural needs of people who used services were met.

Good



# Summary of findings

## Are services well-led?

Staff told us that they felt that the services for people with a learning disability and autism were not seen as a priority for the trust. Staff working in these services, particularly in inpatient services, said they, and the services they provided, were not valued within the trust.

Staff felt well supported by their managers. However, inpatient services were 'stand-alone' services that did not share good practice with each other that could benefit people who used the service.

Improvements to the service were made following feedback from people who used the service.

## Requires Improvement



# Summary of findings

## Background to the service

The trust provides a range of inpatient and community services for people who have a learning disability or autism.

### Services

- Orion Unit assessment and treatment service
- Alexander House locked rehabilitation service
- Hucknall House short break respite service
- Community teams

The Orion Unit cares for up to 18 adults who have a learning disability, complex mental health difficulties and/or challenging behaviours that cannot be managed in the community. The unit, which was opened in November 2013, is based at Highbury Hospital.

Alexander House in Mansfield is a male-only service. It cares for up to eight men with a learning disability who need a locked environment as part of their rehabilitation from low secure services.

Hucknall House is based at Highbury Hospital. It is a short break service for up to five adults who have a learning disability and autism, associated behaviours and/or physical health needs that cannot be supported elsewhere.

The trust also provides a range of community teams. This includes a specialist team for people who have Asperger's, as well as community assessment and treatment teams. Horizon Day Centre at Highbury Hospital also provides an assessment and treatment service. This provides individualised support for people who have complex needs and behavioural challenges, who may find it difficult to access other mainstream services.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Paul Lelliott – Deputy Chief Inspector for Hospitals (Mental Health) Care Quality Commission

**Team Leader:** Jenny Wilkes, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrist, consultant

psychologist, two nurses (one a registered learning disability nurse and one a registered mental health nurse), an Expert by Experience who had used learning disability services, a support worker, a social worker, a Mental Health Act commissioner.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health services inspection programme.

## How we carried out this inspection

To get to the heart of people who use the services' experience of care, we always ask the following five questions of every service and provider:

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

# Summary of findings

We visited Nottinghamshire Healthcare NHS Trust's services for people with a learning disability or autism between 29 April and 2 May. Before visiting, we reviewed information from the provider and looked at feedback from relevant local stakeholders, including the local Healthwatch organisation, advocacy services and focus groups held with people who used the service.

We spoke with community-based staff, including senior community-based clinicians, lead therapists, and other staff. We observed how people were treated, examined treatment plans, and accompanied some community nurses on home visits to people who used the service.

## What people who use the provider's services say

Before the inspection, we used focus groups to speak with people who used the service. During the inspection, we spoke with people on the wards, their family members and some people who used community services.

People in the Orion Unit told us that they felt safe there. They said that staff listened to them and looked after them well. One person said that staff always made the time to listen to people's worries. Two people on the unit told us that they were given information that was in a format they could understand.

People who live at Alexander House said that they felt safe and that staff supported them well.

Relatives told us that the service at Hucknall House was good and they thought their relatives were safe.

People who used the Horizon Day service told us that they could choose the activities they took part in and enjoyed going to the service.

Relatives told us that without the support from staff they would not be able to cope.

People who used community services told us that staff listened to them and were supportive. They said that staff responded when they needed help and always returned their telephone calls, which made them feel supported and valued.

## Good practice

Community nurses supported people to make a DVD of their recovery plan. This helped them to understand what they needed to do to cope with living in the community.

The gardening project at Alexander House helped people who used the service to be independent and develop their skills in growing and preparing food.

People who live at Alexander House told us that their views were listened to at community meetings and action was taken to make improvements in the way they wanted. We also saw how staff supported a person well through a recent bereavement.

A specialist service was provided for people with Asperger's. People who used the service had a comprehensive assessment of their needs, so that they could be better supported in the community.

We observed a community nurse spending time with a person to ensure they had understood and developed the skills that they needed to be independent and safe in the community.

We saw that community teams worked well together, and with inpatient services, to make sure that people who used the service were supported at all stages of their care.

Community teams told us that a supported living service had been developed for three people who had a learning disability and dementia. They told us that this specific service had been shortlisted for an award.

# Summary of findings

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

#### Action the provider **MUST** take to improve:

- The trust must ensure that people who use the services for people with a learning disability or autism, are treated in the least restrictive environment.
- The trust must ensure that in the services for people with a learning disability or autism, people's support plans detail how staff are to safely support each person.
- The trust must ensure that people's physical health is monitored in the Orion Unit.
- The trust must ensure that Section 17 leave forms in the services for people with a learning disability or autism, are specific to individuals and the specific period of leave.
- The trust must ensure that in the services for people with a learning disability or autism, all records for people who use the service are accurate and fit for purpose.

#### Action the provider **SHOULD** take to improve:

- The trust should ensure that in the services for people with a learning disability or autism, the form of physical intervention used is safe for people who have a learning disability.
- The trust should ensure that the locked door policy for Hucknall House states the reasons why doors are locked, so that it is clear that this is in the best interests of people who used the service.
- The trust should ensure that facilities to develop people's skills in independence are safe for people to use in Alexander House.
- The trust should ensure that in the services for people with a learning disability or autism, interpreting services are available when needed.
- The trust should consider encouraging people who use the service at Hucknall House to bring their health and communication plans with them so that information from other members of the multidisciplinary team is shared.
- The trust should consider producing the patient satisfaction survey in a format that all people who use the services for people with a learning disability or autism, can understand.
- The trust should consider improving the environments in Alexander House and Hucknall House.

# Nottinghamshire Healthcare NHS Trust

## Services for people with learning disabilities or autism

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Orion Unit	Highbury Hospital
Alexander House	Mansfield Community Hospital
Hucknall House	Highbury Hospital
Community teams	Duncan MacMillan House

#### Mental Health Act responsibilities

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

We saw in one person's records that it was not clear when they had used the low arousal suite in Orion Unit. When in the low arousal suite they had to ask staff to open the door to go outside which meant that they did not have easy access to fresh air.

In Orion Unit and Alexander House we looked at section 17 leave records for people who were detained under the Mental Health Act 1983. These were not specific to each period of leave that the person had. For example, one

person's section 17 leave form stated, on the same form, that they needed two to one staff support and then one to one staff support. This could put their safety and that of staff accompanying them on leave at risk of harm.

We saw in records sampled in Orion Unit that there was clear evidence that people who were detained under the Mental Health Act 1983 had their rights explained to them. This was produced in an easy to read leaflet enabling all people who used the service to have an understanding. People had information in an accessible format on how to contact an Independent Mental Health Advocate (IMHA) and about their rights to a tribunal. We saw that referrals were made to advocates to ensure people were supported.

One person's records in Orion Unit stated on 24 April 2014 that their detention under section 3 of the Mental Health

# Detailed findings

Act 1983 needed to be rescinded, as they were now able to be discharged from the hospital. However, we saw that this was not done until the day the person was discharged on 29 April 2014. Therefore, there was a delay of five days during which time the person continued to be detained, so the least restrictive principle of the Mental Health Code of Practice was not adhered to.

In Alexander House we saw that people had information about their rights under the Mental Health Act 1983 provided in a format that was easier to understand. We saw that there was good recording of how people had been represented and supported to advocate for their rights.

In Alexander House we saw that people had consented to their treatment under the Mental Health Act 1983. However we saw that the procedure on room searches was not properly linked to the Mental Health Act Code of Practice guidance. In Alexander House we found that staff had misinterpreted the powers contained within this guidance.

## Mental Capacity Act and Deprivation of Liberty Safeguards

In Orion Unit we saw that there were good care plans for assessing people's capacity to make decisions about their health and welfare. However, these were not produced in a format that would be accessible to people who used the service to help them to be more involved in this.

In Orion Unit we found that people, who were not detained under the Mental Health Act 1983, had been referred for a deprivation of liberty safeguards (DoLS) assessment.

In Hucknall House we saw that all doors were locked which included the front door, people's bedrooms, bathroom and the kitchen. There was not a policy on locked doors to show that this decision had been made in people's best interests and not to deprive them of their liberty.

In community teams we saw that people's capacity to consent to their care and treatment had been assessed and was recorded in line with the Mental Capacity Act 2005.

# Are services safe?

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

## Summary of findings

Some of the practices used in inpatient services were restrictive and could put people at risk of harm. In addition, risks were not always fully assessed to ensure that staff knew how to safely support everyone who used the service.

Staff received training in how to protect people from harm and demonstrated that they knew how to do this. They were also given training in managing violence and aggression.

## Our findings

### Orion Unit

#### Track record on safety

All staff spoken with told us they had received training in safeguarding adults from abuse. Staff demonstrated that they knew how and what to report to ensure that people who used the service were safeguarded from harm.

#### Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We looked at four people's medicine records. Each person had been prescribed medicine to be taken when required. We saw that there were clear guidelines for staff to follow as to when this should be given and the medicine had been given safely and appropriately to promote the person's health and wellbeing.

We saw that the building was well maintained and clean to ensure the safety and wellbeing of people who used the service.

#### Assessing and monitoring safety and risk

One person's risk assessments we looked at, were inconsistent regarding the risk the person posed to others, and the risks that other people posed to them. None of the records we looked at included details on how to guide staff in how to support the person if they became aggressive and needed staff to physically intervene to ensure their safety and that of others.

All staff spoken with told us that seclusion was not used. We looked at the policy for the Orion Unit and the use of the short term and long term controlled low arousal suite.

This stated that 'this should only be used for people whose risk to others is a constant feature of their presentation which is not subject to amelioration by a short period of seclusion combined with any other treatment.'

Therefore, to meet the policy, people should not be using the low arousal suite until they have first been secluded.

All staff spoken with told us that the low arousal suite was used for as short a period as possible. We saw documents were available to record the amount of time spent on the suite, however the records were unclear as to the exact location of where people were receiving support and what would lead to them using the low arousal suite.

For example one person had spent long periods of time in the suite. But it was not clear in the records seen if staff were supporting them in the low arousal suite, or the main ward. Staff confirmed that this person had entered the suite voluntarily and by this person being there, other people in the unit were safeguarded from abuse and harm. From looking at the person's records, talking with staff and observations made during our inspection we found that the person was subject to long term segregation.

A lack of accurate records could mean that staff would be unsure as to when the low arousal suite should be used and might mean the patient spent time there unnecessarily.

We saw that this person had been assessed as needing a low secure service. Despite there being a vacancy at one of the services provided by the trust, this person had not been moved.

We looked at the records for one person who was using the low arousal suite on the first day we visited. There were no care plans or risk assessments in place as to why they were using the suite and how staff were to support the person to minimise any risks to their safety and wellbeing when in the suite. These omissions were in breach of the trust policy for the use of this facility.

We wrote to the trust following the inspection and highlighted our concerns in this regard. The trust responded and highlighted the need for this person to be moved with Commissioners, to ensure that people who used the service were treated in the least restrictive environment.

We saw in minutes of a multi-disciplinary team meeting on 15 April 2014 that in preparation for the CQC inspection, the

# 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

# Are services safe?

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

use of segregation beds was to be reviewed and they were now to be called the low arousal suite. The minutes stated that the beds were to be used for people who needed low stimuli, a place to go when people needed some time away from others, not somewhere to go when they had been “bad”. We saw that these rooms did not provide a low stimuli area in that a television and mirror were provided and plans were in place to create murals on the walls in the courtyards. Shelving was provided in this area to store several belongings, which indicated that people could spend longer than brief periods of time in there. People would not normally take several belongings to an area where they were going to calm down and to de-escalate their behaviours.

This meant that the use of this room was unclear and could lead to people who used the service to be placed at risk of harm. The trust responded to this immediately after the inspection and told us that all staff had been instructed to operate within the appropriate practice in keeping with the mental health code of practice. The trust told us that the policy and process were currently being reviewed to agree a safe use of this area to ensure people’s safety and welfare.

Staff told us, and we saw that, when two people who used the service and needed one to one staff to observe them, when in the low arousal suite, this level of observation was reduced to one member of staff. Staff spoken with told us that sometimes when two people had been in this suite, they would both seek attention from the member of staff which made it difficult to ensure that people received the support they needed to ensure their safety. Some observation records we sampled were not fully completed so it was not clear that appropriate levels of observation were maintained which could put people at risk of harm.

All staff spoken with told us they had to receive training in Managing Violence and Aggression (MVA) before they were able to use this. Staff told us that this was only used as a last resort. People’s records that we looked at did not include a plan as to how staff were to support the individual if the diversion techniques stated had not worked, to help them calm down and so staff needed to use MVA.

One person’s records we looked at showed that they had physical health problems. These had not been considered in supporting the person using MVA techniques which could put them at risk of harm.

## Alexander House

### Track record on safety

We saw that the trust took action when concerns were brought to their attention. The manager told us that an allegation had been made about a member of staff from a person who had used the service previously. The alleged staff member had been moved to another place of work where they would not be involved in clinical practice while an investigation took place. We spoke with the manager from the local community learning disability team who would be investigating the allegation. We saw that the allegation had been reported when received and appropriate action had been taken to ensure that people who used the service were safeguarded from harm.

All staff spoken with, including bank staff, told us they had received training in safeguarding vulnerable adults from abuse. They demonstrated that they knew how to recognise and report abuse to ensure that people who used the service were safeguarded from harm.

### Reliable systems, processes and practices to keep people safe and safeguarded from abuse

People spoken with told us that they felt safe and that they would know how to report abuse but had not seen any abuse happening at Alexander House. We saw that there were systems in place to maintain the safety of people who used the service and staff.

### Assessing and monitoring safety and risk

During a handover discussion, we saw that staff expressed concern about the behaviour of one person that if escalated could be a risk to other people who used the service and staff. Staff were concerned that the person may have obtained pornographic material. This was not allowed to be kept in the unit due to the risk that some people who used the service, posed. Staff agreed that they would do a random room search to check this. We discussed this with the manager and looked at the policy for room searches. This stated that searches could be carried out in order to control possession of items which may be dangerous and incompatible with treatment. The person’s records did not say that the access to pornography could be a risk to them and others. Therefore, their risks had not been fully assessed so they could be safely monitored. The manager told us that this would be put in place. They also said that

# Are services safe?

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

they would review and inform people who used the service of which items were contraband in the unit so that all people were aware of this. They said the current information was out of date and needed to be reviewed.

Other people's records we sampled included good plans on how to ensure that staff supported people safely and to monitor the risks they posed to themselves and to others.

## Hucknall House

### Track record on safety

Staff spoken with demonstrated that they knew how to report and recognise concerns of abuse to ensure that people who used the service were safeguarded.

### Learning from incidents and improving safety standards

Staff spoken with told us that when there had been incidents with people who used the service and staff were at risk of harm or abuse, a de-brief session was held. During this they discussed what they did and what they could do better if a similar incident occurred in the future.

A relative told us that all staff who worked at the service were open and honest. They said that when their relative had sustained bruises or scratches when using the service, an investigation took place and they were satisfied with the outcome of this.

### Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw, and staff told us, that they had completed training in safeguarding vulnerable adults from abuse. All staff had completed training in how to de-escalate behaviours which could put the person and others at risk of harm. Staff told us that they planned which people used the service at the same time and this helped to keep people safe and minimise any conflicts.

### Assessing and monitoring safety and risk

We saw that all doors in the building including to people's bedrooms, bathroom and the kitchen were locked. Staff had the keys and people could access rooms by asking or indicating using gestures to staff, that this was what they wanted. Staff told us that all people who used the service lacked the mental capacity to make decisions about their health and welfare so staff made decisions in people's best interests. Relatives of people who used the service we spoke with told us they were happy that the doors were locked as this meant they knew their relative was safe. A policy that stated the reasons why the doors were locked

was not available to ensure that people were not being deprived of their liberty because of this. We saw that information about the doors being locked was not in an accessible format for people who used the service to understand. Staff said that this information was for relatives.

Records we sampled were not clear as to how staff would support people to reduce their agitation and ensure the person and others were safe. Staff spoken with told us that they would try to divert the person's attention and de-escalate the behaviour. All staff were trained in the management of violence and aggression (MVA). Staff told us that there were some incidents of aggression between people who used the service and to staff. They told us that restraint was rarely used but redirection was used. They said, and we saw in records sampled, that as required medicines were only used to calm people down as a last resort.

We saw that the environment was clean and audits completed of infection control, cleanliness and the environment confirmed this.

### Understanding and management of foreseeable risks

The service has been under review for a few years and staff told us that they did not feel part of the trust. Therefore, we did not see any evidence that the impact of planned changes on safety of the service had been assessed to ensure it did not affect the safety of people who used the service.

## Community learning disability team

### Track record on safety

All staff spoken with told us they had received training in safeguarding adults from abuse. Staff demonstrated that they knew how and what to report to ensure that people who used the service were safeguarded from harm.

### Assessing and monitoring safety and risk

We saw that a lone working policy was in place. Staff told us that this was followed and they felt safe when working in the community. We saw that for each person who used the service, a risk assessment had been completed. This meant that the risks to staff and the person were assessed so that action could be taken to minimise these. We observed that when staff visited a person who used the service they showed them their identity badge to ensure that the person knew who was visiting them to promote their safety.

# Are services safe?

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

## **Understanding and management of foreseeable risks**

Staff told us that when a person was referred to the service information was gathered about the person. This included their past history and risk assessments that had been completed previously. Staff told us that if there were any concerns or risks identified then two staff would be allocated to visit the person to ensure the person's safety and that of staff.

We looked at the fire safety procedure at the Ashfield team. This stated that in the event of a fire alarm, it was essential that all fire wardens on duty responded. It stated throughout the procedure that fire wardens were responsible for the safe evacuation of all people in the building until the fire service arrived. However, staff at the office told us that there were no current fire wardens working in the building. This meant that the planning for foreseeable risks had not been managed to ensure the safety of people who used the service and staff.

# 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.

## Summary of findings

The physical health needs of people who used the service were not monitored to ensure their health and wellbeing.

Staff received the training they needed to meet the needs of people who used the service.

The environment in Alexander House and in Hucknall House was institutional, which did not make people feel comfortable and allow them to relax.

Staff from all professions worked together to meet the needs of people who used the service.

The Orion Unit and Hucknall House did not offer a range of activities.

## Our findings

### Orion Unit

#### Assessment and delivery of care and treatment

We looked at one person's medicine record that stated that their blood pressure and pulse should be taken and recorded twice daily. It was unclear why this observation was needed and records showed that staff had not followed this advice. Another person's records stated that their blood pressure, weight and menstrual cycle should be monitored regularly but there was no evidence in their record that this had been done. Another person's records stated that the person had diabetes and for this reason their blood sugar should be monitored twice a day. Records we sampled did not show this had always been recorded twice daily. The person's ward round record stated that their blood pressure was high and should be taken and recorded daily by staff but staff had not followed this advice. In the person's ward round record dated 22 April 2014, it was stated that they needed a blood test. When we looked at their records on 1 May 2014 there was no record that this blood test had been done. We asked staff if this monitoring of people's health needs had been done but not recorded. They told us the monitoring had not been done but had been over looked. The lack of monitoring and recording of people's physical health needs could have a detrimental impact on their health and wellbeing.

### Outcomes for people using services

One person's records recorded the activities that the person had taken part in and those activities that they were offered but had refused. The minutes of their ward round in March 2014 stated that the person should be encouraged to have leave off the unit. However, there was little evidence that this person was offered, or had been supported to take part in, activities outside the unit.

People who used the service, and staff told us, that there were fewer activities available for people in the evenings and at weekends. Staff spoken with told us that they thought if more activities were provided at these times, people would be less likely to behave in a way that could challenge the service.

We saw and staff told us that following meetings about people who used the service, the person was given a copy of the minutes, produced in a format that they could understand. This meant that the person had a record of what was discussed so they knew what their care and treatment was.

### Staff, equipment and facilities

Staff told us, and we saw, that the environment was safe and well maintained and any maintenance issues were resolved quickly.

Staff told us that they received the training they needed to meet people's specific needs.

### Multi-disciplinary working

Records we sampled showed and staff told us that the team of professionals based in the unit worked together to benefit people who used the service. For example, one person's care plan, as how to support them to communicate, included an assessment by the speech and language therapist with clear information for staff supporting the person to enable them to communicate effectively.

We observed a multi-disciplinary team handover and saw that each member of the team contributed and the discussion was constructive to ensure people's treatment was effective and their discharge was planned.

We saw that referrals were made to other professionals to ensure that people had the support they needed. For example, one person was referred to a physiotherapist and had an assessment as to whether or not they needed a wheelchair.

# 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.

## Mental Health Act (MHA)

We saw in one person's records that it was not clear when they had used the low arousal suite. When the person was in the low arousal suite they had to ask staff to open the door to go outside which meant that they did not have easy access to fresh air.

We looked at section 17 leave records for people who were detained under the Mental Health Act 1983. These were not specific to each period of leave that the person had. For example, one person's section 17 leave form stated on the same form that they needed two to one staff support and then one to one staff support. This could put their safety, and that of staff accompanying them on leave, at risk of harm.

We saw in records we sampled that there was clear evidence that people who were detained under the Mental Health Act 1983 had their rights explained to them. This was produced in an easy to read leaflet to enable all people who used the service to have an understanding. People had information in an accessible format about how to contact an Independent Mental Health Advocate (IMHA) and about their rights to a tribunal. We saw that referrals were made to advocates to ensure people were supported.

One person's records stated on 24 April 2014 that their detention under section 3 of the Mental Health Act 1983 needed to be rescinded, as they were now able to be discharged from the hospital. However, we saw that this was not done until the day the person was discharged on 29 April 2014. Therefore, there was a delay of five days during which time the person continued to be detained, so the least restrictive principle of the Mental Health Code of Practice was not adhered to.

## Alexander House

### Assessment and delivery of care and treatment

People's records sampled included clear plans for how staff were to support the person to meet their specific needs and achieve their goals. Before the person was admitted to the service we saw that pre-assessments were completed. This showed that the person's needs could be met there. Assessments also gave staff the information they needed to ensure that risks to people's safety were identified so staff knew what to do to minimise these.

### Outcomes for people using services

People told us, and records we sampled, showed that people had regular health checks and people were

registered with a local GP where they had annual health checks. People told us, and we saw, that each week a men's group was held in the unit where they were supported to learn about their body and what they needed to do to be well.

People were supported to eat healthy foods and learn about what foods would support them to be well. People were supported by staff to go to a local gym and exercise to promote their health and wellbeing.

People told us, and we saw, that a range of activities were offered and people could choose what they wanted to do.

We saw that each person could have their own plot in the garden if they wanted this. Some people were enthusiastic about this and proudly showed us what fruit and vegetables they had grown. People were supported by staff to cook these, which helped them to learn how to grow and prepare their own food. This helped to prepare them for rehabilitation. We saw, and people told us, that they were also encouraged to go out to community allotments and gardening projects if they wanted to do this. One person was out all day at a local college where they had opportunities to do woodwork, arts, crafts, pottery, horticulture and animal care. Staff accompanied the person on these visits to help them to develop their skills and knowledge.

We saw, and staff told us, that audits were completed and the feedback from these was useful in developing the service for the benefit of people who used the service.

### Staff, equipment and facilities

Staff, including bank staff, told us they received the training they needed so they knew how to safely support people who used the service.

We saw that people who used the service were not able to use the washing machine to develop their independence skills, as a part was unsafe and could have caused them harm. Staff told us that this had been unsafe for about six weeks and a new part had been ordered. Staff told us that it could often take a long time to replace equipment which impacted on people's rehabilitation and safety.

### Multi-disciplinary working

We saw that a team of professionals worked together with the person to ensure they received the support they needed.

# 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.

## Mental Health Act (MHA)

Records sampled for people who were detained under the Mental Health Act 1983 did not ensure people's safety when they were going on section 17 leave. The records listed multiple activities for one person with varying ratios of staff. The person's risk assessment was not included with the section 17 forms. This could lead to staff being confused as to the level of support needed on each activity which could put their safety, and that of the person using the service and the public, at risk. We saw that one person's risk assessment for their epilepsy was with their section 17 leave form so staff would know how to support the person if they had a seizure when out on leave.

We saw that people had information about their rights under the Mental Health Act 1983 provided in a format that was easier to understand. We saw that there was good recording of how people had been represented and supported to advocate for their rights.

We saw that people had consented to their treatment under the Mental Health Act 1983.

## Hucknall House

### Assessment and delivery of care and treatment

Staff told us, and records showed, that as part of the pre-admission assessment a home visit was arranged, as were introduction visits for the person and their family. This helped to ensure that the person's needs could be met at the service.

Records we sampled included an individual needs assessment. This was in a tick box format and included limited information about the person's needs. There was no information in people's records about their health needs, for example, when they last saw the dentist or their GP. Staff told us they would ask the person's family if they needed this information. This meant that in an emergency this might delay information being available which could impact on the person's health.

People did not take their health action plan when they stayed at the service which meant that some information about their health needs would not be available during their stay. However, staff told us that each person's needs were discussed with staff during the handover between each shift and if needed support plans were in place which all staff had access to.

## Outcomes for people using services

We saw that most of the people who used the service attended day services. There were limited activities offered in Hucknall House and these were often cooking, arts or crafts. This meant that people were not offered a range of opportunities to develop their interests and hobbies.

Relatives spoken with told us they were happy with the care their relative received there and were involved in their care plans.

### Staff, equipment and facilities

Staff told us, and we saw, that they were well supported and received training to promote their skills and knowledge to meet the needs of people who used the service.

We saw that the environment was not comfortable, but institutional in appearance, which did not promote people's wellbeing when accessing a short stay service.

### Multi-disciplinary working

We saw in records, and staff told us, that when a person came to the service for their stay they did not bring with them their health action plan or communication passport. This meant that staff might not know how other members of the multi-disciplinary team are working with the person to meet their needs which could impact on the person's wellbeing.

### Mental Health Act (MHA)

Staff told us that people who used the service lacked the mental capacity to be involved in decisions about their health and welfare. However, we saw no evidence in people's records as to how their capacity had been assessed.

## Community learning disability teams

### Assessment and delivery of care and treatment

We saw in records, and we observed, that care planning was structured and organised so that all staff who worked with the person knew how to support them in the way they needed and preferred.

We saw that staff were trained in how to positively support a person to ensure their behaviour was managed so that the risks to themselves and others were reduced. This included supporting the person with their communication needs so they could express how they felt, developing their skills, giving them strategies to cope in everyday situations that might make them feel anxious or angry and promoting their self-esteem.

# 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.

We saw that people's capacity to consent to their care and treatment had been assessed and was recorded in line with the Mental Capacity Act 2005. Where people lacked the capacity to consent decisions were made in the person's best interests.

## **Outcomes for people using services**

We saw that people's needs were assessed in line with guidance published by professional and expert bodies. This meant that people's needs were fully assessed so that they could be met in the most appropriate way by the relevant professionals in the community team.

In Horizon day service we saw that each person had a structured timetable of activities offered to them. Where needed these were provided in an easy to read format making it easier to understand.

## **Staff, equipment and facilities**

The environment in the Horizon day service was welcoming and accessible to people who had a physical disability. Moving and handling equipment was provided so that people who had a physical disability could safely use the service.

Staff at Horizon day service told us they felt listened to and supported by the trust.

Staff in community services told us that they had regular training relevant to their role and helped them to develop their skills and knowledge. This also helped them to promote the health and wellbeing of people who used the service.

## **Multi-disciplinary working**

We saw that different professionals in the community and inpatient services worked together to ensure that each person who used the service had their needs met. We saw that relevant information was shared between professionals ensuring they each knew how to support a person to meet their needs. We saw that once a referral had been received, and the person's needs assessed, this was followed up regularly to ensure that the care plan was effective in meeting the person's needs.

# Are services caring?

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

## Summary of findings

Staff were caring and compassionate to the people who used the service.

Staff were genuinely motivated to support people in their recovery and to help them rehabilitate in the community.

People who used the service were treated with dignity and respect.

People's capacity was assessed and where people lacked the mental capacity to make decisions about their care and treatment, decisions were made in their best interests.

number, not by their name. From talking with staff this seemed to be a practice to respect people's confidentiality, however, it could mean that people were not respected as an individual which could affect their wellbeing.

People spoken with told us that they were supported to meet their cultural needs which included the provision of foods that they liked and reflected their cultural background.

People told us that they could attend church every week if they wanted to. However, we saw that two people attended church together but preferred to go to different churches, but due to the number of staff available staff could not support them to do this. So every other week each person went to the church of their choice and the other person went with them. This did not ensure that individuals' needs and preferences were responded to.

At lunchtime we saw that staff sat with people who used the service to eat. The food was prepared for all staff and people who used the service so they could eat together to make it a social occasion. We saw that staff interacted well with people and supported people where needed to ensure their dignity.

We saw, and people and staff told us, that when staff escorted people out in the community staff wore their uniforms. This did not help to promote people's dignity in the community as it labelled them as a person who used a hospital service which could have impacted on their wellbeing. One person told us that it did not bother them that staff wore their uniforms when out in the community with them. However, another person said they did not like this and thought that staff should not wear their uniform or identity badges when going out with them.

### People using services involvement

All people spoken with told us they had been involved in their care plans. People told us, and we saw, that they had access to advocacy services to help support them to say what they needed.

People told us, and we saw, that they were involved in planning menus but if they did not like what was on the menu they were offered an alternative. We saw that people were involved in preparing food and clearing up after mealtimes to promote their independence skills.

## Our findings

### Orion Unit

#### Kindness, dignity and respect

We observed that staff spoke about, and to people who used the service, with respect. We observed that staff were caring, committed and motivated to do their job which benefited people who used the service.

#### People's involvement in using services

We saw that all people who used the service had been referred to advocacy services. We observed that people were reminded of their right to have an advocate during meetings with their multi-disciplinary team.

We saw in 'ward rounds' that the documents used were in a format that was easier to understand so that people who used the service could be more involved in meetings about them.

#### Emotional support for care and treatment

We observed that staff had an understanding of people's individual needs and the importance of supporting people to maintain effective communication with their family.

### Alexander House

#### Kindness, dignity and respect

We observed that staff interacted with people who used the service in a caring way which respected the person as an individual. However, when talking with us and between each other, staff referred to people by their bedroom

# Are services caring?

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

## Emotional support for care and treatment

People told us that staff supported them to maintain contact with their family who could visit them regularly and spend time with them in private.

One person told us, and we saw, how staff had supported them through a recent bereavement and continued to support them by providing a space for them to talk and grieve when they needed it.

## Hucknall House

### Kindness, dignity and respect

Staff spoken with spoke positively about people who used the service.

### People using services involvement

Relatives we spoke with told us they had been involved in interviewing staff to work at Hucknall House which helped to ensure they were happy with the staff employed there. Relatives said they were listened to by the staff which ensured their relative was cared for in the way they needed and preferred.

### Emotional support for care and treatment

Staff promoted relationships with the families of people who used the service ensuring people received the service they needed. Relatives told us that they had good links with the service and felt staff supported and listened to them.

## Community learning disability team

### Kindness, dignity and respect

All staff spoken with were passionate about the job they did and were motivated to ensure that people who used services were safely cared for.

### People using services involvement

We observed that staff spent time with people who used the service to explain their care plan and ensure they agreed with it. We observed that staff used appropriate communication, and made adjustments where necessary, to help people to express themselves and their views about the service provided. We saw that people's relatives, where appropriate, were involved in making decisions about their care.

### Emotional support for care and treatment

One person told us that whenever they telephoned their community team there were usually staff available to help. If not they left a message and staff always telephoned them back as soon as possible.

We saw that staff had supported people who used the service and their family through terminal illnesses and this included staff working outside of their regular hours.

# Are services responsive to people's needs?

Good 

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

## Summary of findings

Community services were flexible to meet people's needs and suit their preferences.

Community teams worked with inpatient services to ensure people's needs were met.

The religious and cultural needs of people who used services were met.

## Our findings

### Orion Unit

#### Planning and delivering services

One person told us that they had not had their hearing aid since they had been there, which was for nearly three months. Staff told us that the person did not come to the hospital with their hearing aid. The person's doctor said during their ward round meeting that a referral was being arranged to the audiology department.

#### Care Pathway

We observed a handover meeting with the multi-disciplinary team. This showed that following the discharge of one person there was liaison with the new care provider to ensure a smooth transition. The person was also referred to the community assessment and treatment team to continue the service until they were settled in their new placement.

#### Learning from concerns and complaints

One person told us that they knew how to make a complaint and when they had done this things changed as a result. Staff we spoke to told us that they knew how to support a person who used the service or their relative to make a complaint. However, they also said that building good relationships with people who used the service, and their relatives, helped to ensure that any concerns were raised and resolved before they escalated to a complaint. This meant that staff responded to people's concerns to ensure that they met their individual needs and preferences.

### Alexander House

#### Planning and delivering services

We saw, and two people told us, that they were supported by staff to access a local community weight reduction

service. Staff told us, and records we sampled, showed that people's physical health had been checked by their doctor to ensure their diet was right for them to follow before they started. We observed that people knew how to monitor their food intake and what food and exercise would help them to be healthy and well.

#### Care Pathway

We saw that staff had a different approach to 'ward rounds' which was less traditional and sought to respond to people's individual needs.

Staff told us, and records we sampled showed, that there were set times for people to smoke and to have hot drinks. Staff told us that there were no safe facilities for people to make hot drinks unless accompanied by staff but people could have cold drinks when they wanted to. We did not see that cold drinks were provided but staff said people had these in their bedrooms. Staff said that the restrictions on smoking and hot drinks were to enable people to take part in therapeutic activities but this reason and rationale was not recorded in people's individual plans. As part of their rehabilitation people were supported to do their own laundry. However, staff told us that a part of the washing machine was unsafe for people to use and had been for about six weeks. Staff told us that the part had been ordered and as a response to us raising this they would chase when this would be done. This meant that people had not been able to develop their laundry skills which could have delayed their rehabilitation.

We saw, and staff told us, that the lounge, activity room and kitchen were locked when not being used. This meant that people had to ask staff to unlock the door when they wanted to go out into the garden. Staff told us that the lounge was open during the evenings but as staff were unable to see clearly into the lounge from other areas, it was not safe for people to have free access to the lounge without staff present. This placed a restriction on people who used the service and did not promote their rehabilitation.

We saw that the service was institutional in appearance and all painted in the same colour. The lounge had some cushions on the chairs however the manager had told us that an inspection by the infection control team suggested these should not be provided. The television was on the wall and positioned in a way which made it uncomfortable for people to look at. The manager told us that they planned to get a new unit and new furniture to make the

# Are services responsive to people's needs?

Good 

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

lounge more comfortable. There were vertical blinds in the lounge but no curtains which did not make it comfortable to relax in. Staff told us this was to avoid risks of harm to people who used the service. However, we saw that the blinds were held on a magnetic rod which people could have easily removed and used as a weapon to harm others or to self-harm.

## Learning from concerns and complaints

We saw that information about how to make a complaint was displayed and available to people who used the service in a format that was easy to understand. People we spoke with told us that they knew how to make a complaint. People said that these would be listened to and action taken to make improvements.

## Hucknall House

### Planning and delivering services

A relative spoken with told us, and we saw in records that we sampled, that there were no set bed times or mealtimes and that snacks were always available. This meant that the service was provided to meet individual needs.

The front door was locked and could only be opened by staff who had the keys. The information about people, who were not detained there under the Mental Health Act 1983, being able to leave the building was not provided in a format that was easy to read. This meant that people who used the service did not have the information about their right to leave when they wanted to. Staff told us that people who used the service would not be able to understand the information and the information provided was for people's relatives. Staff told us that they would know from people's gestures and behaviours that they wanted to go out and would facilitate this when needed.

### Right care at the right time

Staff and relatives spoken with told us that the allocation of people's stay at the unit was based on their individual needs.

We saw that people's cultural and religious needs were met. For example, a male member of staff assisted in bathing a person to ensure the person's cultural needs were met.

## Community learning disability teams

### Planning and delivering services

Psychologists we spoke with told us that interpreters were not always available to work with them which meant they sometimes had to rearrange their clinics to ensure this

service was available for individuals. This included sign language interpreters as well as translators. Psychologists told us that this service was needed regularly but not available.

We saw that where people were unable to wait in waiting rooms, in outpatients departments, appointments were made for staff to visit them at home or at a place where there was more space to move around if needed whilst they waited for their appointment. This meant that the service responded to individuals' needs to ensure their safety and that of others.

Staff spoken with had an awareness of how to meet people's religious and cultural needs. Staff showed that they were sensitive to the person's needs, and that of their family, when visiting them in the community.

### Right care at the right time

Psychologists told us that there were not enough psychologists employed within the trust to provide services to all people, who needed one to one support, and that some people were on waiting lists for over 12 months. Some psychologists told us that they had reduced the impact of this on people who used the service by working with nurses so that they had the skills to do initial assessments. However they expressed concerns that this might only be a short term solution and was dependent on the nurses continuing to work within the team.

We saw that visits from community teams were arranged flexibly to meet the needs of the person who used the service. We saw that Community Assessment and Treatment Teams (CATT) were open from 8am to 8pm, seven days a week. People who used the service told us how this had helped them to get support when they needed it, as they often needed support at weekends. When the service was closed, an answerphone service was available. People told us they had used this and a nurse had got back to them which helped them to feel supported.

### Care Pathway

We observed that referral meetings were attended by representatives from each profession in the multi-disciplinary team, for example psychologists, nurses, occupational therapist and speech and language therapist. We saw that each professional was involved in the discussion as to how to meet the person's needs and plan for their care.

# Are services responsive to people's needs?

Good 

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

## Learning from concerns and complaints

We saw that advocacy was promoted throughout the service so that people would have the support to raise concerns and complaints if they needed to. However, we found that information about how to make a complaint was not always in a format that was accessible to people

who used the service. Several staff spoken with told us that complaints would be raised with them and then taken forward. This meant that if a person wanted to make a complaint about the member of staff that always supported them, this complaint might not be heard.

# 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.

## Summary of findings

Staff told us that they felt that the services for people with a learning disability and autism were not seen as a priority for the trust. Staff working in these services, particularly in inpatient services, said they, and the services they provided, were not valued within the trust.

Staff felt well supported by their managers. However, inpatient services were 'stand-alone' services that did not share good practice with each other that could benefit people who used the service.

Improvements to the service were made following feedback from people who used the service.

## Our findings

### Orion Unit

#### Vision and strategy

Staff spoken with did not have an awareness of the trust vision and strategy for the next year. One staff member was aware of the trust plans to achieve foundation trust status.

#### Leadership and culture

The Orion Unit was amalgamated from two wards in different areas of the county in November 2013. All staff spoken with told us that the management team had led this well so that the transition went smoothly. We saw that the amalgamated staff team worked well together.

Staff we spoke to told us that they received regular supervision which they found useful in discussing how they were performing in their job role, if they had any concerns and what training and development needs they needed to improve their skills and knowledge.

### Alexander House

#### Vision and strategy

Staff spoken with told us that across the trust they felt that the learning disability services were not valued, particularly the inpatient services. Staff told us that they had put in a joint commissioning bid with a mental health unit on the same site. The bid was successful for both units however Alexander House was not mentioned in the article in the trust magazine. This made them feel they were not valued as a staff team and as a service.

### Leadership and culture

All staff spoken with told us that the manager of the unit was a good leader and they felt well supported by them. However, all staff spoken with told us that the service had not been recognised by the trust for what they had achieved. They felt that as a service they were not valued by the trust and lacked financial input and leadership because of this.

### Engagement

We saw that meetings were held every month with people who used the service. The minutes of these were displayed in communal areas so that people who used the service could see what actions were agreed and who was responsible for these. People told us that their views were listened to and improvements were made in the way they wanted as a result of these meetings.

We saw, displayed in the dining room, suggested areas for improvement that people who used the service had made, and information about what had been done as a result of these.

### Hucknall House

#### Vision and strategy

Staff told us that the service had been under review by the commissioners for several years, as it was not clear whether this service that provided a healthcare environment was needed. For this reason there had been no new referrals to the unit for over 12 months. Therefore, people who used the service had been there for several years and staff knew them and their families well.

Staff told us that, as the service was under review, they were a forgotten service and did not feel valued by the trust as a whole.

### Leadership and culture

Staff told us they received regular supervision, accessed regular training and professional development, attended conferences and had opportunities to shadow staff in other units and teams. The team leader, as part of the leadership training they were doing, was undertaking an audit of the unit's admission checklist and assessment. This meant that they were using the skills they had gained in training to develop the service to benefit people who used it.

# 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.

## **Engagement**

People who used the service were unable to express their views about the service and be involved in the running of it due to their needs. However, we saw that their relatives were involved in interviewing staff and coffee mornings were held at the service to ask for their views.

## **Community learning disability teams**

### **Vision and strategy**

Staff spoken with told us that they shared practice across the region and the trust. Teams were integrated with health professionals and social workers all working together to benefit people who used services. Staff told us that they received information regularly about the vision and strategy of the trust and were aware of this and how it impacted on their role.

### **Responsible governance**

We saw that audits were completed of community services provided. These provided knowledge about how well the service was performing and what could be done to make improvements. We saw that improvements to services had been made as a result of these.

### **Leadership and culture**

Several staff told us that they received regular supervision and appraisals which were focussed and useful to the member of staff in improving their performance.

Psychologists spoken with told us that there was no professional lead for psychologists within the trust to the board level. This meant that psychology services were not always given the priority needed to promote the wellbeing of people who used the service.

We saw that teams worked together and shared practice across each other and with external providers and networks. This meant that best practice was shared to benefit people who used the service.

## **Engagement**

Staff told us that they had introduced a three box plan where people who used the service were encouraged to put a token into a box regarding how they felt about the service provided. This meant that different ways to ask for people's experiences of the service had been explored so as to involve people as much as possible. We saw that staff used different methods of communication to ensure that they had feedback from all people who used the service.

However we saw that the trust 'patient satisfaction survey' was not produced in a format that was easier to understand, which could mean that some people might not be able to express their views of the service provided.

## **Performance Improvement**

One member of staff told us that they had been given interview technique advice from one of the directors of the trust which had been really helpful. Another member of staff told us about how the Chief Executive had assisted and supported them in their research proposal. This meant that staff were supported to improve their own performance which benefitted the trust as a whole.

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by means of carrying out of an assessment of the needs of the service user and the delivery of care and treatment to meet the service user's individual needs and ensure their welfare and safety.</p> <p><b>The way the Regulation was not being met:</b> People's support plans and assessments of potential risk did not sufficiently detail how staff were to safely support each person and ensure they were treated in the least restrictive environment.</p> <p>There was insufficient monitoring and recording of people's physical health needs in Orion unit.</p> <p>Regulation 9 (1) (a) (b) (i) (ii)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	<p>The registered person did not have suitable arrangements in place to protect service users against the risk of control and restraint being unlawful or otherwise excessive.</p> <p><b>The way the Regulation was not being met:</b> There were no care plans or risk assessments in place on Orion Unit to demonstrate why staff were using the low arousal suite and how staff were to support the person to minimise any risks to their safety and wellbeing.</p> <p>Regulation 11 (2) (a) (b)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>The registered person must ensure that service users are protected against the risks of unsafe or inappropriate</p>

# Compliance actions

care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

**The way the Regulation was not being met:**

Section 17 leave forms were not specific to individuals and the specific period of leave.

Records for people who used the service did not include detail to guide staff in how to support the person if they became aggressive and needed staff to physically intervene to ensure their safety and that of others.

Regulation 20 (1) (a)