The WoodHouse Independent Hospital

Quality Report

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Date of inspection visit: 18th - 20th February 2020
Date of publication: 24/04/2020

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

The WoodHouse provides services for patients with a learning disability or autism in a range of small, bespoke units and cottages. The service offers assessment, treatment and rehabilitation placements, individualised and intensive packages of care and step down to community-based services. The service is specialist in providing care for individuals with autism and forensic histories.

Following our inspection in June 2019 we placed the service in special measure because it did not have enough suitably qualified and skilled staff to deliver safe care to patients with learning disabilities and autism.

On this inspection we found that the provider had made a number of improvements identified as being required at the last inspection but found further areas that needed improvement. However, we have judged that enough improvement has been made to remove the provider from special measures.to remove the provider from special measures.

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

- Not all units were clean or well-maintained to uphold patients dignity. Staff did not have knowledge and understanding in the operation of anti-barricade doors and may not be able to gain access to a patient who is in need or at risk quickly to intervene.
- Although the provider had changed its approach to care planning since the last inspection, staff did not always develop care plans for all patients that were recovery-orientated or person centred, and they did not clearly identify patients' needs and goals.
- Staff did not always assess and record capacity clearly for patients with specific physical healthcare needs, who might have impaired mental capacity to make decisions. Consent to treatment for physical healthcare needs was not always assessed and recorded.
- Staff did not actively involve patients and families in decisions about their care. There was no patient perspective in care plans as they were not written in collaboration with patients.
- Some of the governance processes did not ensure that units ran smoothly. The service had begun to implement a local audit schedule; however, it was not always clear that actions resulting from audits were addressed. Information in paper-based systems was not always accurate or up to date and did not reflect the information stored on the electronic patient information system.

However:

- The units had enough nurses and doctors. Staffing levels and use of agency staff had improved since the last inspection. Staff assessed and managed risk well, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- The service provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability (and/or autism) and in line with national guidance about best practice. Staff had begun to engage in clinical audit to evaluate the quality of care provided.
- The unit teams included or had access to the full range of specialists required to meet the needs of patients on the units. Managers ensured that these staff received training, supervision and appraisal. The unit staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Staff managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

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Summary of this inspection

Background to The WoodHouse Independent Hospital

The WoodHouse is an independent mental health hospital provided by Elysium Healthcare (Acorn Care) Limited. Following the last inspection in June 2019 this hospital was placed under the CQC's special measures regime.

The WoodHouse provides services for patients with a learning disability or autism in a range of small, bespoke units and cottages. The service offers assessment, treatment and rehabilitation placements, individualised and intensive packages of care and step down to community-based services. The service is specialist in providing care for individuals with autism and forensic histories; including sexual offending, highly complex and severe challenging behaviour. It provides care for up to 37 male patients under 65 years old who have learning disabilities or autism.

The WoodHouse hospital comprises of eight units located on a rural site in Cheadle, Staffordshire:

- Hawksmoor, three beds, locked rehabilitation with self-contained apartments;
- Lockwood, eight beds, locked rehabilitation unit
- Farm cottage, three beds, open rehabilitation house
- WoodHouse cottage, three beds, open rehabilitation house
- Moneystone, eight beds, autism complex/ challenging behaviour unit
- Whiston, four beds, autism complex/challenging behaviour self-contained apartments
- Highcroft, four beds, autism rehabilitation unit
- Kinglsey, four beds, autism complex/challenging behaviours self-contained apartments

The WoodHouse hospital is registered to provide the following regulated activities:

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

The service did not have a registered manager at the time of inspection. The current hospital director was going through the registration to be the registered manager. Since the inspection, the hospital director has become the registered manager.

We last carried out a comprehensive inspection for this hospital in June 2019, we rated it as inadequate overall.

We rated safe, caring and responsive as requires improvement and effective and well-led as inadequate. We issued the hospital with one warning notice which related to:

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- All units did not have enough nursing staff of all grades to meet the needs of the patients and no adequate systems and processes in place to mitigate the risks associated with high use of agency.
- The provider did not accurately calculate and review the number and grade of nurses and support workers for each shift to allow staff to get rest breaks and regular breaks from enhanced observations according to the National Institute for Health and Care Excellence (NICE) guidance.
- There was a lack of clear leadership at unit level and that staff on duty were always experienced and had the right skills and knowledge to meet the needs of the patient group.
- The provider did not ensure that the units had good staff skill mix and that all staff including agency had received specific training to equip them with the right skills required for working with people with learning disabilities or autism. Staff had not received the necessary specialist training for their roles.
- The provider did not ensure that there was a comprehensive structured induction programme for agency staff to all the units.
- Staff were not supported with appraisals, regular supervision and opportunities to update and further develop their skills.

Summary of this inspection

- The service have addressed all of the above and there has been a marked improvement.

We also issued the hospital with four requirement notices which related to:

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

- Care plans did not always reflect the assessed needs and were not always personalised, holistic and recovery-oriented. This has not improved since the last inspection.
- Staff were not always aware of care plans and positive behavioural support plans to use this information to enhance the quality of patient care.
- The needs of patients with specific communication needs were not adequately met.

Regulation 11 HSCA (RA) Regulations 2014 Need for Consent

- Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision where they might have impaired mental capacity.

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- The ligature risk assessments lacked clear actions on how the risk identified was to be managed. However, this has improved since the last inspection.
- Staff did not always follow systems and processes to safely store and manage medicines.
- Physical health was not consistently monitored, patients with constipation had no care plans in place and bowel monitoring charts were not always completed.

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The governance processes did not operate effectively at all levels and that performance and risk were not managed well.
- Staff did not participate in clinical and internal audit processes and they did not function well and had a positive impact on quality governance.
- The checks made by staff were not reliable and valid as a true reflection of what was held in the emergency bag in Moneystone.
- There was no clear learning from incidents discussed with staff, both internal and external to the service and that managers and staff were not aware of the Learning from Deaths Mortality Review (LeDeR) Programme.
- The provider did not carry out an autism friendly assessment to ensure that the environment was therapeutic for patients with autism and that the patient dynamics was adequately and regularly reviewed to ensure the environment was comfortable for all patients.

The rating of inadequate led the CQC to place the location into Special Measures. The local CQC inspection team has met regularly with the provider and colleagues from the local Clinical Commissioning Groups to oversee the improvement plan before inspecting the hospital.

Our inspection team

The team that inspected the service comprised five CQC inspectors and a variety of specialists: one consultant psychiatrist in learning disabilities, one nurse specialist in learning disabilities, one speech and language therapist and two experts by experience.

Summary of this inspection

Why we carried out this inspection

We inspected this service as a six month follow up inspection to the service being placed in special measures and to follow up on a warning notice issued last inspection in June 2019.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information. This was an unannounced inspection.

During the inspection visit, the inspection team:

- visited seven units at the hospital as Hawksmoor unit was closed, and looked at the quality of the unit environment and observed how staff were caring for patients;
- spoke with 12 patients who were using the service;
- spoke with the hospital director and other senior managers including the regional lead nurse, lead nurse and a nurse manager;
- spoke with 35 recovery workers and nurses;
- spoke with 15 other staff members; including doctors, nurses, occupational therapists, psychologists, mental health act administrator, quality and compliance administrator, physical care coordinator, staff engagement lead and a speech and language therapist;
- spoke with five carers;
- spoke with an independent advocate;
- attended and observed one morning meeting and one multi-disciplinary meeting;
- looked at 15 care and treatment records of patients:
- carried out a specific check of the medicines management on all units; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that they felt safe and that staff were caring, polite and treated them with dignity and respect.

Patients told us that their physical health needs were met and that they were taken to see the GP or to the hospital, should they need to.

Patients informed us that were offered a copy of their care plan but were not always involved in writing and developing their care plans.

Patients told us that there were not enough drivers and vehicles on site and that this impacted on their leave being cancelled.

Carers told us they felt that their loved ones were safe and that they had enough activities to do both on site and on their section 17 leave.

Carers felt that staff were always very friendly, polite and had a caring attitude towards their loved one. They were always informed when there were changes to their loved ones medicines.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Our rating of this service stayed the same. We rated it as requires improvement because:

- Not all units were clean or well maintained.
- Staff did not have knowledge and understanding in the operation of anti-barricade doors and may not be able to gain access to a patient who is in need or at risk quickly to intervene.
- Staff did not always have access to the clinical information required to maintain high quality clinical records. There were multiple systems used to store information, therefore it was not always clear which information was the most up to date.
- Staff did not always follow best practice when storing medicines. Staff did not always record the date of opening of new creams and liquids; therefore, could not assure they were still effective when given to patients.
- Staff did not always follow the National Institute for Care Excellence guidance and the organisation policies in the allocation of staff to observations. Staff could be allocated to observing patients with enhanced observations or being made available to support patients requiring periodic observation for long periods of time.

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff understood how to protect patients from abuse and 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.
- Staff mostly assessed and managed risks to patients well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempt's at de-escalation had failed. Staff participated in the provider's restrictive interventions reduction programme.

Summary of this inspection

- Staff regularly reviewed and recorded the effects of medicines on each patients physical health. They knew about and worked towards achieving the aims of stopping over-medication of people with a learning disability, autism or both (STOMP).
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team and the wider service. When things went wrong, staff apologised and gave patients and carers honest information.

Are services effective?

Requires improvement

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

- Care plans were not personalised or recovery orientated and did not detail patients individual aims and goals.
- Care plans were reviewed regularly through multidisciplinary discussion; however, details of these discussions were not recorded on the electronic system.
- Staff did not always assess and record capacity clearly for patients with specific physical healthcare needs, who might have impaired mental capacity to make decisions. Consent to treatment for physical healthcare needs was not always assessed and recorded

However:

- Staff assessed the physical health of patients on admission. They developed care plans for physical healthcare needs which they reviewed regularly through multi-disciplinary discussion and updated as needed.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, to support self-care and the development or everyday living skills, and to meaningful occupation. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.
- The teams had access to the full range of specialists required the meet patient's needs. Managers ensured that staff had the range of skills needed to provide high quality care. They supported staff through supervision, appraisals and development opportunities. New staff were provided with an induction programme.
- Staff from different disciplines worked together to benefit patients and to ensure that there were no gaps in care. There were effective working relationships with other relevant teams within the organisation and those outside of the organisation.

Summary of this inspection

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity in most areas except for physical health.

Are services caring?

Good

Our rating of this service improved. We rated it as good because:

- Patients told us they felt safe and that staff treated them with dignity and respect.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff actively sought for patient feedback on the quality of care provided and ensured all patients had access to an advocate.
- Staff informed and involved families and carers appropriately.

However:

- Care plans were not written in collaboration with patients or family and carers and did not include the patients perspective.

Are services responsive?

Good

Our rating of this service improved. We rated it as good because:

- There was always a bed available when needed and patients were not moved between units unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design and layout of the units supported patients treatment and privacy. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. The food was of good quality.
- There was access to work and education opportunities for all patients both within and external to the service.
- The service met the needs of patients including those with a protected characteristic. Staff helped patients with communication, advocacy and culture and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and ensured these were shared with the wider service.

Summary of this inspection

Are services well-led?

Requires improvement 

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

- Managers were not always approachable to staff and patients on the units.
- Our findings from other key questions demonstrated that not all governance processes operated safely and effectively at unit level, despite systems and procedures in place to monitor the quality and performance of the service.
- The service did not always collect reliable information or analyse it to understand performance or enable staff to make decisions and improvements. The information systems were not integrated. Not all staff had access to the information they needed to provide safe and effective care and treatment.
- Staff were not equipped with the right skills to continually improve services and did not have a good understanding of quality improvement methods.

However:

- The hospital director had been in post for three months at the time of the inspection and had started to make some positive changes. Managers had a good understanding of the services and could clearly explain how the team was working to provide high quality care.
- Staff knew and understood the providers vision and values and how they were applied in the work of their team. Staff were able to tell us what the values of the service were.
- Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Leaders managed performance using electronic systems such as dashboards to identify, understand monitor and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromise the quality of care.
- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.
- Leaders encouraged innovation and participation in research.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. As of February 2020, 90% of staff had had training in the Mental Health Act.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was.

The provider had relevant policies and procedures that reflected the most recent guidance. If there were any updates or changes to policies and procedures, managers would email staff the updates.

Staff had easy access to local Mental Health Act policies and procedures and to the code of Practice via the intranet.

Patients had easy access to information about independent mental health advocacy. Advocates were invited to patient meetings and staff supported patients to access advocacy services. Any patients that lacked mental capacity were referred to the independent mental health advocacy service.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Patients told us that their rights were read to them on a regular basis. There were easy read versions of rights available to support patients.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients detention papers and associated records correctly and so that they were available to all staff that needed access to them.

The Mental Health Act administrator carried out regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

As of February 2020, 84% of staff received training in the Mental Capacity Act and deprivation of liberty safeguards. This training for mandatory for all clinical staff and was updated on a yearly basis.

Most of the staff that we spoke to had a good understanding of the Mental Capacity Act 2005 and its five statutory principles.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and knew how to access this via the intranet.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards. Staff told us that they would contact the Mental Health Act Administrator.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

Not all units were clean and well maintained. Staff did not have knowledge and understanding in the operation of anti-barricade doors.

Not all units were clean and well maintained. Moneystone units floor was dirty and there were several large areas of paint that had chipped away from the wall. The floors on the clinic room on Moneystone and Kingsley were both dirty. Cleaning records were up to date and demonstrated that the unit areas were cleaned regularly, but that these areas were not cleaned during the inspection.

Staff did not know how to operate anti-barricade doors across all units and had not been provided with training in their operation. Anti-barricade doors are fitted in units where there is a risk a patient may lock themselves in their rooms. They allow staff to remove the door and gain access in an emergency. There were different anti-barricade systems on different units, some of which required a key that was not immediately available, and staff were unable to inform us where this key was. On Highcroft unit, a patient had been at risk of self-harm in their bedroom, the risk of possible harm would be increased if staff could not quickly intervene. The inspection team raised these concerns with the service during inspection, and this was acted upon to ensure that staff had knowledge in how to operate these systems.

There were ligatures points on all units within the service. These are places to which patients intent on self-harm might tie something to strangle themselves. There were a number of anti-ligature fixtures and fittings installed where possible to reduce risk. There were ligature risk assessments in place for each unit and ligature footprints detailing ligature points displayed in the office areas. However, on Highcroft this had not been updated to reflect current ligature risks. For example, the ligature risk assessment stated that there were curtain rails on the unit, which were no longer there. The ligature risk assessments had not been updated since July 2019 to reflect these changes.

Staff were able to observe patients in all parts of the unit, although areas in Moneystone and Whiston had blind spots the use of mirrors mitigated any risk. However, on Kingsley there was not a mirror in place to enable staff to see around the corner to the upstairs apartment. and when leaving the upstairs apartment and entering through the doors to the main corridor.

There was closed circuit television in place throughout the hospital. The coverage extended to social areas of the units and was used to support the investigation of incidents.

Staff completed and regularly updated risk assessments of all units areas and removed or reduced any risks they identified. There were environmental risk assessments in place for each unit and a service wide health and safety group that met on a regular basis

The units were all male and complied with guidance on same sex accommodation.

Staff had easy access to alarms and radios and a member of staff was allocated for security at the start of each shift. There were no nurse call systems in place on the units, however if a patient was identified as needing a call system, this was facilitated on an individual needs basis.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Where resuscitation equipment was not located in a clinic room, there was signage to inform staff where to locate it. However, on Lockwood unit, there was not clear signage to inform staff that there was oxygen located within the clinic room.

Staff maintained equipment well and kept it clean. Any 'clean' stickers were visible and in date.

Staff adhered to infection control principles, including handwashing. There was a case of methicillin-resistant staphylococcus aureus (MRSA) on one of the units and staff were provided with personal protective equipment (PPE) such as gloves and aprons and training in infection control. There was a care plan in place to support the management of MRSA for the patient.

Safe staffing

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

The service required an establishment of 24 whole time equivalent qualified nurses and 149 support workers across all units. The vacancy rate had decreased since the last inspection in June 2019 where the nursing vacancy rate was 42% and support worker vacancy was 40%. At 19th February 2020, there were six whole time equivalent (33%) nursing vacancies and 29 (25%) support worker vacancies at the time of inspection. The service had also increased the number of bank nurses and bank support workers since the last inspection with two whole time equivalent nurses and 32 whole time equivalent support workers, subsequently the number of shifts filled by agency staff had decreased. Since the last inspection, a number of agency staff had converted to substantive posts within the service. Bank and agency staff are used to cover the vacancies and any sickness. They are included within core staff teams on the units and the service had provided them with an induction and specialist training to ensure they are equipped with the skills necessary to provide quality care to the patient group.

Managers had calculated the number and grade of nurse and support workers based on patients individual care packages and the number of patients on enhanced observations. The service had implemented a 'safe staffing' tool to indicate the core number of staff on each shift across the site and on each unit. The tool indicated when staffing fell below the planned number of staff but maintained safe staffing, and when staffing fell below the planned number of staff and was deemed unsafe.

Managers could adjust staffing levels daily to take account of case mix. When necessary, managers deployed bank and agency nursing staff to maintain the safe staffing levels. Additionally, there was a site coordinator for each shift that was responsible for ensuring safe staffing levels and covering shifts, reviewing staffing numbers and skill mix across the units. Some staff told us that they felt that were not enough staff to respond if there was an incident.

The staff turnover rate for the service in the six-month period from September 2019 until February 2020 was 9.9%. There was a peak in resignations in December 2019 and January 2020, but these were due to personal reasons. The sickness rate in the six-month period prior to inspection was 5.2%, some of this was explained due to long term sickness.

Staffing levels allowed patients to have regular one-one time with their named nurse. If a patients named nurse was not available, there was always at least one staff member allocated to be supporting each patients, depending upon their package of care, to provide one to one time.

There were enough staff to carry out physical interventions safely. Physical observations were carried out on a weekly basis and more regularly for those with a clinical need.

A qualified nurse was not always present in the communal areas of the units at all times. During the morning meeting, the charge nurses and nurse representative from each unit would attend, which mean that there was not a qualified nurse available across the site. Managers told us that they would be able to respond to an alarm if raised, as the meeting is held on Whiston unit. There was also one nurse or charge nurse on shift on each unit, except on Farm cottage and WoodHouse cottage who shared nurses with Lockwood and Moneystone units where the nurses were predominantly based. Staff told us that this made it difficult at times to get their break, go to the toilet and support patients. There were two patients based on Farm cottage at

the time on inspection who needed support from staff with kitchen access and access to a computer. If patients wanted to access these at the same time, recovery workers found it difficult to facilitate if they were lone working. Patients on WoodHouse and Farm cottage told us that they would have to wait for a nurse to come from the other units to administer their medicines before going on leave, which they found frustrating and that lone working affected the ability to attend some sessions. There were always recovery workers in communal areas, however there was often only one recovery worker on each of the cottages. The service had a lone working policy in place, however staff were not aware of this and the protocols to follow.

There had been a reduction in the number of staff who rotated to support the units from 9am to 5pm, which had reduced from eight to three. Staff told us that they were not always able to take their breaks due to this reduction. Staff shortages rarely resulted in staff cancelling escorted leave or unit activities. However, staff and patients told us that leave was sometimes cancelled due to shortages in the number of staff that were drivers and access to the services vehicles.

Medical Staff

There was adequate medical cover day and night and a doctor could attend the unit quickly in an emergency. There was a doctor on site during the weekdays and an out of hours system to ensure that a doctor could attend site when needed.

Managers were able to use locum doctors to provide additional medical cover. There was one permanent and one locum doctor who covered five days between them.

Mandatory Training

Staff had completed and were up to date with their mandatory training. The compliance for mandatory training as of 18th February 2020 was 88.5%. Managers monitored training compliance and alerted staff when they were due to update any of their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients well. They achieved the right balance between maintain safety and providing the least restrictive environment possible to support patients recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempt's at de-escalation had failed. Staff participated in the provider's restrictive interventions reduction programme.

We looked at 15 patient records and found that each of them contained a risk assessment. Staff used an appropriate recognised risk assessment depending upon the individual needs of the patient and carried out a risk assessment for each patient on admission. This was updated on a regular basis, including after any incident.

The hospital had introduced core staff teams which meant that staff worked on the same unit on each shift. This was to ensure that staff knew the risks to each patient on the unit and were able to prevent and reduce these risks. Each patient had a detailed positive behaviour support plan and staff demonstrated good knowledge of these plans. Positive behaviours support is an approach that is used to support behaviour change in an adult with a learning disability. They were able to tell us different risks and triggers and the steps that they would take to reduce that risk for each patient. It was evident that staff working on the units knew the patients well and clearly understood their behaviours, their risks and how to safely support them.

Staff rarely carried out searches on patients or their bedrooms but followed good policies and procedures when they did so, to keep them safe from harm. Staff did so when indicated as necessary and clearly recorded their reasons why.

Staff individually risk assessed patients and did not impose blanket restrictions. Staff and patients told us that there was varied access to kitchens and bedroom fobs, dependent upon the individual patients risk assessment. The service had carried out an audit on blanket restrictions in January 2020.

There were no seclusion facilities at the service and managers reported that they would not admit a patient that required the use of seclusion. There had been no instances on long-term segregation from August 2019 until February 2020. The service reported that they would find alternative ways of managing patients, rather than through the use of long-term segregation.

Staff used restraint only after de-escalation techniques had failed, and in line with patients individual positive behavioural support plans. There had been two occasions where prone restraint had been used from August 2019

until January 2020. During the same period, there were 1010 incidents of restraint. This had increased since the last inspection which detailed that there were 882 incidents of restraint in the six-month period prior to the inspection in June 2019. Staff reported any physical contact with a patient as an incident of restraint and classified different types of restraint. The use of mechanical restraint was not permitted at the hospital.

All incidents were reported through the electronic reporting system which all permanent staff had access to. Incidents were reviewed on a weekly basis by the multi-disciplinary team through the introduction of an incident analysis meeting, which looked at physical interventions and restraints on each unit to identify themes and trends.

The service participated in the restrictive interventions reduction programme. The service had implemented a reducing restrictive practice meeting to be held on a quarterly basis to ensure that staff were supported in their understanding of reducing restrictive practice, but this was very much in its infancy.

There had not been any episodes of rapid tranquilisation from August 2019 until January 2020.

Observations on patients were carried out in a therapeutic way. We observed good interactions and engagement with patients. Observations were reviewed at multidisciplinary meetings in line with risk and after any incident.

Staff did not always follow good policies and procedures for the use of observations. Intermittent checks were carried out every 15 minutes at set times and were not varied. On Highcroft unit, there were three occasions during one-night shift were one staff member had completed the checks on two patients at the same time. Descriptions for observations were very limited and did not include a lot of detail, for example 'appears asleep'. Throughout all units, staff were assigned to observations for long periods or rotated from one set of observations to another, without having a solid break. This did not follow National Institute for Health and Care Excellence guidelines (NG10) to ensure that individual staff members do not undertake a period of continuous observation above general observations for longer than two hours. We observed an allocation rota that detailed a staff member rotating observations between two patients for five hours, one of whom was on intermittent 15-minute checks and had two staff members available to them. Not all staff had a clear understanding of the difference in observations with care packages and enhanced observations. Enhanced observations are prescribed to support and manage patients through acute illness or stress. They require staff members to consistently observe patients due to their risks. Care packages do not specify how many staff members should be with the patient at all times, they are the maximum number of staff need to manage patients on a general day to day basis. Patients are admitted to the service under a care package that is based on their care plan and the cost of managing the patient on a daily basis.

Safeguarding

Staff understood how to protect patients from abuse and 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.

The service made 28 safeguarding referrals between August 2019 and February 2020. The service had no serious case reviews commenced or published for the same reporting period.

Staff knew how to protect patients from harassment and discrimination and gave examples of occurrences where they had done so.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked well with other agencies such as the local authority. Staff gave an example of reporting another member of staff for inappropriate behaviour towards a patient on the unit. Managers reviewed closed circuit television (CCTV) and took appropriate action against the staff member and reported the incident to the local authority safeguarding team.

Staff knew how to make a safeguarding referral, who the safeguarding lead was and how to escalate any concerns that they had.

Staff received training in safeguarding as part of their mandatory training and could recognise abuse and understood how to apply their training within their roles.

Staff followed safe procedures and policy for children visiting the service. There were meeting rooms located away from the units where children were able to meet with patients safely.

Staff access to essential information

Staff did not always have access to the clinical information required to maintain high quality clinical records. There were multiple systems used to store information, therefore it was not always clear which information was the most up to date.

Information that was available to staff was not always up to date or relevant to the patient. There were grab packs which had observation details, monitoring charts and other patient information essential to maintain their safety. There were also orientation folders which had relevant patient information to inform new staff to the unit. Information in grab packs and orientation folders were out of date, not paginated and on three occasions had the previous organisation's logo on. Therefore, new starters or agency staff would not have the most up to date information to care for patients. Not all agency staff could access the electronic patient information system and would have to rely upon the paper documentation to provide information about how to care for patients.

The service used an electronic patient information system to store patient information securely.

Medicines management

The service had systems and processes to prescribe, administer or record medicines. Staff regularly reviewed and recorded the effects of medicines on each patients physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). Staff did not always follow best practice when storing medicines.

The units had appropriate arrangements for the management of medicines. Medicines were stored securely in a locked cabinet in the clinic rooms on each unit. There were no clinic rooms on Highcroft, Farm cottage or WoodHouse cottage, so medicines were kept in a locked cabinet. Clinic rooms were very small on all units. Staff recorded the temperature of the clinic room and the fridge on a daily basis, ensuring that they were within a safe range.

Patient medicines was reviewed on a monthly basis by the consultant during multi-disciplinary meetings and patients received specific information about their medicines, such as side effects. Information was provided both verbally and written, however easy read information provided to patients around their medicines was inconsistent across the units.

There were systems in place to ensure that staff knew about safety alerts and incidents to ensure patients received medicines safely.

The service worked towards achieving the aims of STOMP (Stop Over Medication of People with a learning disability, autism or both). Stop Over-Medicating People is a national improvement programme to help people to stay well and have a good quality of life. It focuses on ensuring patients work with staff and the people who support them to get the right care and treatment, have regular medicine reviews, make sure they are taking the right medicines for the right reasons, and find other ways for patients to stay well.

Staff reviewed the effects of medicines on patient's physical health regularly and in line with the National Institute of Health and Care Excellence Guidance, especially for those patients who were prescribed high dose antipsychotic medicines. Blood monitoring was carried out on a regular basis and there were bowel monitoring charts were in place to monitor the side effects of high dose antipsychotic medicines.

During our inspection we found that there were creams and liquids that had been used but did not have a label to indicate when they had been opened, or a date of disposal. Where staff had written the dates of expiry, for example with erythromycin zinc, they were still using the medicine three weeks after the expiry date. Continued use of this specific product could lead to increased risk of patient infection, due the risk of using a product that is no longer at full strength and possible cross contamination. Other creams and liquids had the date of opening but did not have the date they should be discarded; therefore, they could not be sure that they were still effective when treating patients. Clinic room audits were carried out on a weekly basis, and clinic room books were viewed on a daily basis at the morning meeting. The pharmacist carried out audits on a six-monthly basis and had carried out an audit in January 2020. The average compliance across all units was 78.3%. The audit had highlighted a number of areas for action, one of which was that products with a limited shelf life indicated a date of opening and disposal on them.

We found that there was an oxygen cylinder in Lockwood clinic room that staff did not know was there and there was no signage to indicate its location. This meant that staff

would leave the unit to locate an oxygen cylinder if required and could cause a delay to treatment. This was also highlighted through the pharmacy's audit that there was no signage to emergency bags and equipment.

Track record on safety

The service had a good track record on safety and reported that there were three serious incidents from August 2019 until February 2020.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventable measures are in place. This service reported that there were not any never events during the above reporting period.

From October 2019 to January 2020 the hospital recorded 18 staff with 28 injuries, injured through restraint and assault.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team and the wider service. When things went wrong, staff apologised and gave patients and carers honest information.

All staff knew what incidents to report and how to report them. The service used an electronic incident reporting system that was available to most staff. Some agency members of staff did not have access to the system and so were unable to report incidents and had to ask another member of staff with access to the system. Therefore, it was not always possible to tell if those incidents were reported accurately or at all.

Staff reported all incidents that they should report. Incidents were discussed every day at the morning meeting. The service had recently implemented an incident analysis meeting to review incidents and identify themes and trends on a weekly basis at a unit by unit level.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Most staff told us that they received a debrief and support after an incident, but there were occasions where they had not.

Managers investigated incidents thoroughly and involved staff, patients and families in their investigations where relevant.

Staff received feedback from investigation of incidents, both internal and external to the service through team meetings which had recently been implemented across the service. Lessons learnt were discussed at team meetings and distributed via email and posters displayed throughout the site.

There was evidence that changes had been made as a result of feedback. Staff had raised concerns about the environment for one patient and managers had listened to this feedback and made the relevant changes to support staff to meet the patient's needs.

Managers and staff were aware of the Learning from Deaths Mortality Review (LeDer) Programme. Managers had attended meetings and staff had signed up to receive updates. The service was following the programme initiatives such as making reasonable adjustments when attending the local hospital, developing links with a learning disability liaison nurse and the implementation of National Early Warning Signs (NEWS).

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Care plans were not personalised or recovery orientated and did not detail patients individual aims and goals. They were not written in collaboration with patients or family and carers and did not include the patients perspective. Care plans were reviewed regularly through multidisciplinary discussion; however, details of these discussions were not recorded on the electronic system.

We reviewed 15 care records. They demonstrated that staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after admission. However, care plans were not personalised, holistic or recovery orientated. Care plans did not clearly identify patients goals, were not person centred and did not clearly focus on individual needs. Care plans were not person

centred and were not written in collaboration with the patient and lacked the patient's voice and own words. Care plans were not written in a clear and structured way, with patient needs, goals and risk management mixed together. Some care plans were very long with lots of information in a single care plan. This made care plans hard to follow and did not provide clarity in how to care for and meet the individual needs of patients.

Staff updated care plans when necessary on the electronic system, however they did not update the paper copies that were held for care plans and positive behaviour support plans, within orientation folders and grab packs. This meant that staff that were not familiar with working on the unit would not have the correct or up to date information to be able to care for patients. Particularly those staff members that did not have access to the electronic system, such as agency staff.

All patients had details of physical health within care plans, however they were very generic for those patients that did not have an identified physical health problem. We found that one patient who did not smoke had details about smoking and advice around smoking cessation. Care plans for diabetes were not personalised and included generic information such as 'people with diabetes are at risk of. There were detailed care plans in place for those patients with specific physical healthcare problems such as epilepsy and constipation.

Staff assessed patients physical health needs in a timely manner after admission. All patients had a full physical health assessment within 48 hours of admissions, to identify any physical health problems and staff recorded this on the electronic system. All patients had received an up to date annual health check from the GP. Outcomes from hospital or GP visits were also recorded on the electronic system.

All patients had an up to date hospital passport which was fully completed and included meaningful information that was specific to the patient. A hospital passport is a document for people with learning disabilities that contain their health needs and other useful information such as likes, dislikes and their preferred method of communication.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, to support self-care and the development or everyday living skills, and to meaningful occupation. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.

We looked at 15 care records and 23 prescription charts. Staff provided a range of care and treatment interventions suitable for the patient group. The medical and psychological interventions used were those recommended and were delivered in line with National Institute for Health and Care Excellence. We observed some patient activity groups during our inspection noting good patient engagement and interaction.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. The service had introduced the role of a physical care coordinator to ensure that patients appointments were arranged and facilitated. The service had established good links with the learning disability liaison nurse at the local acute hospital and other local services such as the dentist, opticians and GP. The service had a contract with a local GP who would visit patients if they were unable to attend the GP surgery. There was good access to specialists such as neurology for those patients with epilepsy. Patients had their physical healthcare observations carried out on a weekly basis on site.

Staff assessed and met patients' needs for food and drink and for specialised nutrition and hydration. The speech and language therapist carried out assessments for dysphagia, for those patients who had difficulties with swallowing, and was able to support patients and develop care plans around this. We spoke with a patient who was following a soft food diet following a dysphagia assessment. We saw evidence that staff were completing food and fluid charts regularly for identified patients. Staff were able to make referrals to a dietician when required.

Staff supported patients to live healthier lives through various groups such as a walking group, healthy lifestyle group and fitness group. Patients also received information regarding smoking cessation and healthy eating. Regular exercise was promoted at the service and patients were supported to access the gym and the local swimming pool.

Requires improvement

Wards for people with learning disabilities or autism

Staff used recognised rating scales to assess and record severity of patient conditions and treatment outcomes. The Health and Nation Outcome Scales was completed on admission and at six monthly intervals for every patient.

Staff did not participate in benchmarking and quality improvement initiatives. The hospital had a local audit programme and had carried out audits for care plans and mental capacity and developed an action plan to implement improvements.

Skilled staff to deliver care

The teams had access to the full range of specialists required the meet patients needs. Managers ensured that staff had the range of skills needed to provide high quality care. They supported staff through supervision, appraisals and development opportunities. New staff were provided with an induction programme.

The team included a full range of specialists required to meet the needs of patients on the units. This included two consultants, nurses, recovery workers, two occupational therapists, two psychologists, one speech and language therapist, occupational therapy assistants and psychology assistants.

Staff were experienced and qualified. Since the last inspection the service had equipped staff, including agency staff, with the right skills and knowledge to meet the needs of the patient group. Staff had completed specialist training in autism, epilepsy, diabetes, Makaton, and picture exchange communication system (PECS). Core staff teams had been established for each unit since the last inspection so that staff worked predominantly on one unit to provide regular and consistent care to patients.

Managers provided new staff with an appropriate two-week induction and new staff were not included in the staffing numbers on the units for several days. Agency staff were also provided with an induction and had a checklist to complete prior to working on the units.

Managers supported staff through regular clinical supervision and appraisal. The service had introduced a supervision tree to ensure that all staff knew who their supervisor was and had relaunched supervision passports, a document to record that supervision had taken place and track when it was next due. There had been a marked increase in the proportion of staff that had received appraisals and supervision, however supervision was still being embedded within the service. At the previous inspection in June 2019, only 20% of nursing staff had received supervision and as of 31st January 2020, 75% of nursing staff had received recent supervision and 95% of nursing staff had received an appraisal. Most of the staff that we spoke with told us that they had received supervision recently and had received an appraisal within the last 12 months.

The service had introduced team meetings since the last inspection in June 2019. These ran across two units and were supported by a nurse manager and included agency and bank staff as part of the units core teams. We reviewed minutes from these meetings which demonstrated that managers informed staff of any changes or important information and that staff were able to raise any concerns that they had.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. All qualified nurses were provided with leadership training and clear roles and responsibilities were defined for charge nurses as leading the unit and for leading shifts as the nurse in charge.

Managers dealt with poor staff performance promptly and effectively. Support from the human resources department was available to managers if needed.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together to benefit patients and to ensure that there were no gaps in care. There were effective working relationships with other relevant teams within the organisation and those outside of the organisation.

Staff shared information about patients and their care at effective handover meetings within the team. Handovers took place at the start of each shift in the morning and evening. We saw evidence of detailed handover sheets which gave a comprehensive overview of each patients presentation and care for that shift. There were also morning meetings that took place every weekday to review each unit and included information on; incidents, staffing levels, safeguarding, physical healthcare, complaints, referrals, unit dynamics, security and a dashboard review. Each meeting was minuted and there were actions that were followed up at the next meeting.

Requires improvement

Wards for people with learning disabilities or autism

The unit teams had effective working relationships including good handovers, with other relevant teams within the organisation. There were regular discussions with the occupational therapy, psychology and catering teams and the teams visited the units on a regular basis.

The unit teams had effective working relationships with teams outside the organisation. There were good working relationships with the local authority, local acute trust, GP and dentist.

Staff held multidisciplinary meetings on a monthly basis. The details of these meetings and the discussions around patients care were not documented on the patient information system. Therefore, it was not clear to see what had been reviewed or discussed and the effectiveness of these meetings.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. As of February 2020, 90% of staff had had training in the Mental Health Act.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was.

The provider had relevant policies and procedures that reflected the most recent guidance. If there were any updates or changes to policies and procedures, managers would email staff the updates.

Staff had easy access to local Mental Health Act policies and procedures and to the code of Practice via the intranet.

Patients had easy access to information about independent mental health advocacy. Advocates were invited to patient meetings and staff supported patients to access advocacy services. Any patients that lacked mental capacity were referred to the independent mental health advocacy service.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Patients told us that their rights were read to them on a regular basis. There were easy read versions of rights available to support patients.

Staff ensured that patients were able to take Section 17 leave (permission to leave hospital) when their leave had been granted. However, a number of staff and patients told us that there were issues in accessing vehicles and drivers which resulted in leave being cancelled. The hospital director told us that there were plans to increase the number of drivers on site and that taxis could be utilised to ensure that patients leave was facilitated. The service were being proactive to address the issue by ensuring that as part of recruitment, those who were able and willing to drive hospital vehicles were put through the necessary checks and training to ensure that there were more drivers available. The hospital also introduced a Monday meeting to look at each unit's schedule for the upcoming week, to ensure that there was suitable transport and staffing to facilities all patients' leave, visits and appointments.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients detention papers and associated records correctly and so that they were available to all staff that needed access to them.

The Mental Health Act administrator carried out regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Care plans did not refer to identified section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Good practice in applying the MCA

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity in most areas except for physical health.

As of February 2020, 84% of staff received training in the Mental Capacity Act and deprivation of liberty safeguards. The regional safeguarding lead had provided a number of

information and training sessions to staff to support them with their understanding of the Mental Capacity Act. Most of the staff that we spoke to had a good understanding of the Mental Capacity Act and its five statutory principles.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and knew how to access this via the intranet.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards. Staff told us that they would contact the Mental Health Act Administrator.

Most staff took all practical steps to enable patients to make their own decisions before deeming that a patient did not have capacity. The practice of providing patients with easy read information was inconsistent and varied across the units. There was good practice on Highcroft unit where folders were placed in communal areas in the lounge areas for patients to access whenever they needed to.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. We saw evidence of detailed capacity assessments in place for patients consent to treatment and for financial needs. However, we found that not all patients with a physical healthcare need had a capacity assessment in place for consent to treatment, where they may have impaired capacity. For example, a patient had a refused an epilepsy bed monitor on numerous occasions but a capacity assessment had not been carried out.

When patients lacked capacity, staff made decisions in their best interests, recognising the important of the persons wishes, feelings, cultures and history. However as capacity assessments for physical healthcare were not in place, we could not be assured that they were considered.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies. The service had not made any deprivation of liberty safeguards applications in the six months prior to the inspection.

The service had arrangements to monitor adherence to the Mental Capacity Act. The service had carried out an audit on the application of mental capacity. The audit had identified some areas for improvement and some patients that did not have capacity assessments in place. The actions from the audit were placed on the hospital wide action plan.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. We observed staff interacting with patients in a caring nature, supporting them to meet their needs.

Staff supported patients to understand and manage their care, treatment or condition. Staff supported patients to maintain their independence where possible in areas such as cooking and laundry and engaging in leisure activities in the community. Some patients self-medicated and staff supported patients to ensure they were safe and able to do so.

Staff directed patients to other services when appropriate and if required, supported them to access those services. All patients were registered with the local GP and dentist.

Patients said that staff treated them well and behaved appropriately towards them. They spoke positively about feeling safe and staff being polite and respectful.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Patients told us that they were supported to access religious services in the community and engage in leisure activities such as swimming.

Requires improvement

Wards for people with learning disabilities or autism

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff were able to provide examples of occasions where they had reported inappropriate behaviour towards patients.

Staff maintained the confidentiality of information about patients in line with policy.

Involvement in care

Staff actively sought patient feedback on the quality of care provided and ensured all patients had access to an advocate. However, staff did not involve patients in their care.

Staff used the admission process to orient patients to the unit and to the service. There were welcome packs available for patients that were also available in an easy read version.

Patients were encouraged and supported to attend their multi-disciplinary meetings to discuss their care and treatment.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. The service had provided staff with training in the use of picture exchange communication system (PECS) and Makaton, a language programme that uses signs and symbols to help people communicate, to support patients communication needs. During inspection, the use of PECS to communicate with a patient was observed and demonstrated good staff knowledge in how to use the system and to meet the patient's needs and support choice.

Staff involved patients when appropriate in decisions about the service. Patients had recently been invited into clinical governance meetings for a portion of the meeting. Patients on WoodHouse cottage told us that they were able to choose the colours for the lounge.

Staff enabled patients to give feedback on the service they received. There were regular community meetings where patients were able to raise any concerns that they had. The service also carried out patient surveys to obtain feedback.

Staff enabled patients to make advance decisions on their care when appropriate.

Staff did not always involve patients in their care. Patients perspective was not always evident in care plans and patients told us they did not always have access to a copy of their care plan. Where patients required easy read material to support them, this was not always available, and was not consistent from unit to unit.

Staff informed and involved families and carers appropriately.

Staff informed and involved families and carers appropriately and provided them with support when needed. Carers told us that there were able to obtain information via telephone about their relative when they needed to. All carers were invited to attend multidisciplinary meetings, care and treatment reviews and care programme approach meetings, with the permission of their relative.

Staff enabled families and carers to give feedback on the service they received. The service had comment cards in the reception area to enable carers to give feedback. Carers told us that they were able to raise any concerns that they had.

Staff provided carers with information about how to access a carers assessment. We saw evidence of a letter that the hospital had sent to all carers to provide this information. The carers that we spoke with informed us that they had received this.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between units unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons. However, discharge plans were not used consistently within the service.

Requires improvement

Wards for people with learning disabilities or autism

The average bed occupancy from September 2019 until February 2020 was 62%. At the time of inspection, Hawksmoor unit was currently not in use as there were no patients on the unit.

The provider accepted referrals from the whole of England. The average length of stay was 28 months. There were three patients who had been at the hospital for longer than 10 years due to a restriction order from the home office and so were not included in this data.

Beds were available when needed for patients living in the catchment area. The service was operating under capacity at the time of inspection.

There was always a bed available when patients returned from leave.

Patients were not moved between units during an admission episode unless it was justified on clinical grounds and was in the best interests of the patient.

When patients were moved or discharged, this happened at an appropriate time of day.

It would be unlikely for a patient to require a bed at a psychiatric intensive care unit (PICU). However, should the need arise, the service would continue to care for the patient until a more suitable bed was sourced.

In the six months prior to inspection, there were no delayed discharges.

The service complied with transfer of care standards.

Staff supported patients during referrals and transfers between services. Transition periods between services were agreed with new providers, offering support at the service and patients having periods of leave at their new provider. If a patient had an acute hospital admission, staff from the service would stay and provide support.

During the inspection, we found that not all patients had a discharge plan in place and information from multi-disciplinary meetings was not recorded on the patient information system to demonstrate discussions around discharge. However, patients had care programme approach meetings to discuss discharge and each patient had a care and treatment review in line with the transforming care agenda. During our inspection, a patient was on transition leave to a new placement and was discharged the following day.

The facilities promote recovery, comfort, dignity and confidentiality

The design and layout of the units supported patients treatment, privacy Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. The food was of good quality.

Patients had their own bedrooms with en-suite facilities. Hawksmoor, Kinglsey and Whiston units provided self-contained apartments where patients had their own lounge and kitchen areas.

Patients were able to personalise their bedrooms and apartments with their own belongings. We saw photographs, posters, personal bedding and other personal belongings in bedroom areas.

There were lockable facilities in patient bedrooms for patients to store away their personal possessions. Not all patients had keys to their bedrooms, as this was individually risk assessed to maintain patients safety and was managed well within the service.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. The service had introduced a sensory room that was available on site for all patients to use and contained items such as lighting, bean bags, rocking chairs and other sensory items such as playdoh and texture boards.

Not all of the units had dedicated quiet areas. Some units had apartments which enabled patients to have somewhere quiet to go. Other units had bedrooms and communal areas such as the dining room and lounge. There were rooms located off the units where patients could meet visitors.

Some patients across the units had access to their mobile phone, which was individually risk assessed to maintain patient safety and was managed well. If a patient did not have access to their own mobile phone, there was a unit mobile phone that they could use to make telephone calls in private.

Patients had access to outside space. Patients on Highcroft and Moneystone units did not have easy access to outside space as the units were located upstairs.

Patients were able to make hot drinks and snacks 24/7, depending upon their individual risk assessment.

Requires improvement

Wards for people with learning disabilities or autism

The service offered a variety of food and most of the patients we spoke to said that the food was of good quality. There were easy read menus available for patients, however it was not clear that they were used consistently across the units.

There were some concerns about the patient dynamic and environment on Moneystone unit. The environment was not conducive to meet the needs of patients with autism. The unit was noisy and during the inspection there was a patient who was consistently banging loudly which was disruptive, and the lights were very bright throughout the communal areas, which may affect the sensory needs of some patients. However, the provider had carried out an autism friendly assessment (autism friendly checklist) to meet the national guidelines for an autism friendly environment National Institute of Health and Care Excellence clinical guidelines [CG142]. There were a number of areas identified on the checklist for improvement. The service had developed and action plan to address those issues to improve the environment, patient dynamics and sensory needs.

Patients' engagement with the wider community

There was access to work and education opportunities for all patients both within and external to the service.

Staff ensured that patients had access to education and work opportunities. The occupational therapy team had developed a therapeutic work placements scheme, where patients were employed to carry out certain jobs such as car maintenance, patient café and typing the newsletter. Roles were designed around patients ability and there were 16 placements for patients running at the time of inspection. Patients were also supported with work placements in the community such as at the local radio station and the local charity shop.

Staff supported patients to maintain contact with their families and carers. The service had a family day and invited family and friends to attend. Carers were able to telephone their relative and visit the service. The service also facilitated home leave for patient to visit their relatives.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. During our inspection, there were a number of patients on section 17 leave accessing community services such as swimming.

Meeting the needs of all people who use the service

The service met the needs of patients including those with a protected characteristic. Staff helped patients with communication, advocacy and culture and spiritual support.

Training had been implemented in the use of picture exchange communication system and Makaton to support patients with specific communication needs. During our inspection we saw picture exchange communication system in use with a patient who had communication difficulties, enabling the patient to communicate their needs effectively, with good understanding from the staff.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain and this information was available in an easy read format.

Information leaflets could be made available in languages spoken by patients, on an individual needs basis.

Managers ensured that staff and patients had easy access to interpreters and/or signers when needed.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

Staff ensured patients had access to appropriate spiritual support. Some patients told us that they attended a local church when accessing the community. There was also a multi-faith room on site available for patients to use.

The information provided was in a form accessible to the particular patient group. Information was made available in easy read such as care plans, however we found that these were not being used consistently across each unit.

The service had made adjustments for disabled patients or visitors to the service. Moneystone and Highcroft had lifts to ensure disabled patients had access to the units. Whilst there was not a lift to access the reception area which was located above a flight of stairs for patients or visitors to access for meetings, there were areas on the ground level, such as the barn, that patients or visitors could access.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and ensured these were shared with the wider service.

Requires improvement

Wards for people with learning disabilities or autism

The service received five complaints in the last six months, one of which was upheld, one was partially upheld and none were referred to the Ombudsmen. The service received three compliments in the same period.

Patients knew how to complain or raise concerns. There were regular community meetings where patients had a forum to raise any concerns. Patients would ask staff to complete a complaint form which was available in an easy read version.

When patients complained or raised concerns, they received feedback.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to handle complaints appropriately and tried to resolve patient concerns firstly at a unit level. They would then speak to the nurse in charge or the nursing manager and raise the concern with them. Patients told us that they felt able to raise concerns and complaints, should they need to.

Staff received feedback on the outcome of the investigation of complaints and acted on the findings. Lessons and changes in practice from complaints were made and shared with staff.

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

Requires improvement

Leadership

The hospital director had been in post for three months at the time of the inspection and had started to make some positive changes. They had a good understanding of the services and could clearly explain how the team was working to provide high quality care. However, they were not approachable to staff and patients on the units.

The service had strengthened the senior management team, introducing a lead nurse and another nurse manager, however this change was still being embedded within the service. The senior management team consisted of the hospital director, lead nurse, two nurse managers that were responsible for four units each, the principle psychologist, the lead occupational therapist and the consultant psychiatrist. This ensured that senior managers were able to fully carry out their roles and responsibilities. Charge nurses are responsible for overseeing their units and managing, supervising and assisting the nursing staff, as well as providing administrative support and patient care. The hospital had introduced charge nurses and recruited more since the last inspection, however there were still only 10 charge nurses across eight units. This did not allow cover for training or annual leave or for a charge nurse taking the role of the site coordinator. This meant that during each shift pattern there were only three or four charge nurses leading the unit.

The hospital director had only been in post for three months at the time of inspection, however they had a good understanding of the service they managed and had previous experience in leading learning disabilities services. The regional lead nurse for Elysium had been acting as the interim hospital director prior to this and had developed a hospital assurance plan in response to the last inspection to address the areas for improvement. They understood the challenges that the hospital faced and were working towards improving these. They clearly explained how teams were working to provide high quality care to patients.

Leadership development opportunities were available, including opportunities for staff below team manager level. The service had introduced leadership and management training for charge nurses and nurses to clearly define their roles and tasks and to support them in carrying out those tasks. Supervision training for level 3 recovery workers was being introduced for those recovery workers to supervise level 2 and level 1 recovery workers, to take some of the volume of work away from nurses. Nurse associate training was available for recovery workers.

Managers took part in quality walk arounds and visited the units and recorded their visits to each unit and completed a report. However, some staff felt as though these were a tick box exercise and did not hold any value. Some staff felt as though senior managers were not approachable and did not listen to or support staff concerns. Staff reported that the nurse managers had good presence on the units, but there was less visibility from the lead nurse and hospital director, who did not visit the units often.

Vision and strategy

Staff knew and understood the providers vision and values and how they were applied in the work of their team. Staff were able to tell us what the values of the service were.

The services senior leadership team had successfully communicated the providers vision and valuers to the frontline staff. Vision and values were discussed as part of the induction and training process. Additionally, an information sharing display was located in the staff room which rotated various useful information, including the vision and values of the service.

Staff had the opportunity to contribute to discussions about the strategy for their service especially where the service was changing. Staff were involved in discussions about the introduction of a staff room and car parking, with staff suggestions sought for ideas.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Most staff told us that they felt respected, supported and valued. They felt positive and proud about working for the service and their team. The introduction of core staff teams including bank and agency staff provided a stable and cohesive staff team for each unit which staff valued. Staff told us that morale had improved since the last inspection due to action that the provider had taken to make improvements.

Staff felt able to raise concerns without fear of retribution. Managers took concerns seriously and provided staff with support when necessary. There had been occasions where staff had raised concerns and had felt positive that there was action taken and no retribution on themselves.

Staff knew how to use the whistleblowing process and about the role of the Freedom to Speak Up Guardian and felt able to use both processes.

Managers dealt with poor performance when needed. There had been occasions when agency members of staff had displayed inappropriate behaviours towards patients or not complied with hospital procedures. Those staff members were immediately removed from the site and informed that they would no longer be able to work at the service.

Teams worked well together and where there were difficulties, managers dealt with it appropriately.

Staff appraisals included conversations about career development and how it could be supported. There were a number of development opportunities available to support staff development.

The service reported a staff sickness rate of 5.2%, from August 2019 until January 2020. This was above the provider target and had increased since the last inspection where sickness was at 2.5% from June 2018 to May 2019.

Staff had access to support for their own physical and emotional health needs through an occupational health service and were signposted to this when necessary.

The provider recognised staff success within the service through a staff awards system to recognise staff achievement.

Governance

Our findings from other key questions demonstrated that not all governance processes operated safely and effectively at unit level, despite systems and procedures in plan to monitor the quality and performance of the service.

Not all units were clean despite systems and procedures being in place. There were inconsistencies with the recording of information. Multidisciplinary meeting discussions were not always recorded on the electronic system therefore it was not clear to see the details of what had been discussed and any changes to care that had been made as a result.

When records were updated electronically, paper copies were not simultaneously updated, leading to different versions of patient documentation such as care plans and positive behaviour support plans. If staff did not have access to the electronic system, they could not be sure that the paper information was up to date to enable them to provide quality care to patients.

Staff undertook local clinical audits; however they were not sufficient to provide assurance and staff did not always act on the results when needed. Despite an audit of mental capacity assessments being carried out, there were not

capacity assessments in place for several patients physical healthcare needs. Additionally, audits did not always pick up on errors and when they were, they were not always acted on. For example, areas highlighted from the pharmacy were not acted upon. When audits were competed, action plans were put into place. There was a service wide action plan where actions from different audits were compiled to give an overarching service level action plan.

There was a clear framework of what must be discussed at a unit level in team meetings to ensure that essential information, such as learning from incidents and complaints was shared and discussed. Each team meeting had a clear agenda for discussion.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at service level. Managers attended regular LeDer meetings and fed information and recommendations into clinical governance meetings, which were distributed to the wider staff team.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patient. The service had established good working relationships with some commissioners, local authority, local community, local acute hospital, GP, dentist and the voluntary sector.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand monitor and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromise the quality of care.

Managers maintained and had access to the risk register at unit level. Staff at a unit level did not have access to the risk register but could escalate any concerns to managers when required. Some staff concerns matched those on the risk register, but there were some that did not. For example, the concerns around a patient with methicillin-resistant staphylococcus aureus (MRSA) and the management of this. MRSA was not identified on the risk register. The risk register had not been updated since December 2019 and there were items on the register that had ceased the time for review.

The service had plans for emergencies such as adverse weather and internet failure. These plans set out the actions to follow to ensure the safety of all patients and staff was maintained in the event of an emergency or adverse weather conditions.

There were not any cost improvements taking place at the service. The service was operating under capacity and managers informed us that they were selective with patient referrals, ensuring that they were appropriate and would not compromise the existing patient mix.

The sustainability of delivering quality care could be compromised as there were financial pressures to increase the capacity of bed numbers. However, the hospital director told us that the acceptance of referrals would still follow the same process and there would not be a sudden influx of admissions, they would be staggered to ensure sustainability. The service would continue with their recruitment strategy and would not admit patients if there were not the correct staffing levels to support their delivery of care.

Information management

The service did not always collect reliable information or analyse it to understand performance or enable staff to make decisions and improvements. The information systems were not integrated. Not all staff had access to the information they needed to provide safe and effective care and treatment.

Information was not in an accessible format and did not identify areas for improvement. Care plans were not clear or well written. Information regarding patients risk management was displayed in different care plans and was not clearly defined. The multiple information systems were not integrated. Information in paper-based systems was not always accurate or up to date and did not reflect the information stored on the electronic patient information system.

Staff did not always have access to the equipment and information technology needed to do their work. Some agency staff told us that they did not have a log in to the electronic patient information system, so other nursing staff would enter clinical information for those staff.

The information technology infrastructure, including the telephone system worked well and helped to improve the quality of care. The intranet provided staff with information

such as policies, lessons learnt and a newsletter. The service had issues with the internet service which sometimes caused electronic systems not to work adequately and meant that access to the electronic patient information system was very slow. We witnessed this on inspection and the service quickly acted to improve the internet strength. The hospital director told us that there were plans in place to increase the internet provision, but there had been some delays due to the internet provider and location of the service. There was a contingency plan in place for when the internet went down and downtime forms to complete to ensure patient information was not missed. These would then be uploaded retrospectively.

Information governance systems included confidentiality of patient records. Patient information was stored securely both electronically and paper based.

Team mangers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers had access to a live dashboard which monitored a number of key areas of the service performance and indicated when patient information, such as care plans or risk assessments were due to be updated.

Staff made notification to external bodies as needed such as the local authority, the Care Quality Commission and commissioning groups.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had up to date information about the work of the provider and the services they used. Staff had access to the intranet and received information through team meetings, newsletters and emails. Patients had regular community meetings where information was shared. Carers that we spoke with told us that communication from the service had improved and they were able to obtain up to date information about their relative. There was a website which detailed information about the service.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Carers had the opportunity to complete feedback forms about the service received. There were regular meetings and surveys for both patients and carers to provide feedback. Advocacy services were able to support patients to provide any feedback. The service had developed a staff engagement lead post full time to ensure that staff were able to raise any concerns or give feedback to this individual.

Directorate leaders engaged with external stakeholders such as commissioners and the local authority.

Managers and staff had access to the feedback from patients, carers and staff and used it make improvements and changes within the service.

Patients and carers were not always involved in decision making about changes to the services.

Patients and staff could not always meet with members of the providers senior leadership team to give feedback. We spoke with a carer who told us they had been trying to speak with the hospital director but were told they were not able to.

Directorate leaders engaged with external stakeholders such as commissioners and Healthwatch. The service had engaged positively with the CQC and the local clinical commissioning group on a monthly basis, to develop and implement their assurance and improvement plan.

Learning, continuous improvement and innovation

Leaders encouraged innovation and participation in research. Staff were not wholly committed to continually improving services and did not have a good understanding of quality improvement methods.

Staff had opportunities to participate in research. The forensic psychologist was completing a piece of research with the patient group and had sought input from members of staff across the service.

There was evidence of some innovation taking place at the service. The therapeutic opportunities and work experiences for recovery (TOWER) project was a good piece of work to support patients with real life work opportunities. The psychology team were continually reviewing the latest psychological methods and tools to work with patients.

Staff were not given the time and support to consider opportunities for improvement and innovation to lead to changes. Whilst there was a regional quality improvement

lead with input into the service, and quality and compliance administrator at a service level, there was not a local quality improvement lead, who had responsibility for leading the services quality improvement initiatives.

Whilst the service was carrying out some audits to improve quality, staff were not using quality improvement methods and did not know how to apply them. There was a lack of knowledge and skill for staff in the use of quality improvement methods.

Staff were not participating in national audits or accreditation schemes relevant to the service to identify any learning.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that care plans are personalised, recovery orientated and written in collaboration with the patient. Regulation 9 (1)(c)(3)(a)(b)
- The provider must ensure that there are capacity assessments in place for patients with specific physical healthcare needs who demonstrate impaired capacity and that consent to physical healthcare treatment is clearly assessed and recorded. Regulation 11(1)
- The provider must ensure that all staff have knowledge and understanding in how to operate anti-barricade doors across the unit. Regulation 12(2)(c)
- The provider must ensure that there are robust governance processes in place to ensure that information is up to date, areas for improvement identified through audit are acted upon. Regulation 17(1)
- The provider must ensure that actions from audits are addressed and there is clear learning to support improvement in processes. Regulation 17(2)(a)
- The service must ensure that patient information that is used to provide care is contemporaneous and accurate. Regulation 17(2)(c)

Action the provider SHOULD take to improve

- The provider should ensure that all units are clean and well maintained.
- The provider should ensure that there is clear signage to locate all emergency bags and oxygen on site.
- The provider should ensure that all medicines with a limited shelf life were clearly labelled with their opening date and date of disposal.
- The provider should ensure that staff understand and follow good policies and procedures for the use of observations, lone working and the updating of ligature risk assessments.
- The provider should ensure that staff are able to take their breaks.
- The provider should ensure that senior managers are approachable for staff and patients.
- The provider should consider adding mirrors to Kingsley unit corridor to ensure clear lines of sight.
- The provider should consider the involvement of families and carers in developing patient care and treatment.
- The provider should consider participating in national audits and quality improvement initiatives.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance