Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust

Wards for people with a learning disability or autism

Inspection report

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Date of inspection visit: 28 April 2021 to 10 May 2021
Date of publication: 15/07/2021

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Inadequate**
Are services responsive to people's needs?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

Wards for people with a learning disability or autism

Inadequate ⬤ ↓↓

We expect Health and Social Care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people.

Our rating of this location went down. We rated it as inadequate because:

- The service could not show how they met the principles of Right support, right care, right culture.
- The service was not safe. Staff did not have the training and skills to care for people and respond to their needs. Medicines were not managed safely; there was no policy or protocol regarding people self-administering medicines or care plans for as needed medicines. Staff had not responded to safeguarding concerns and taken the necessary action to safeguard people from abuse.
- The service was not effective. People did not receive person centred care; care plans were lengthy and people and those close to them were not involved in the development of their care. Staff did not have the specialist training to support people with a variety of needs. The multidisciplinary team was not effective, with a divide between the multidisciplinary team and nursing team. Patients did not receive outcome focussed care and treatment in line with national best practice. Communication was poor, staff providing the care were not up to date with the plans for each person at the service.
- The service was not caring. We saw staff ignoring people's request of basic needs of food and drink. Staff talked amongst themselves rather than engaging with people. Relatives were not involved in the care of their relatives.
- The service was not responsive. Discharge planning was poor, and people had long lengths of stay. Relatives were not involved in the discharge planning for their relatives. Staff were not meeting the needs of people at the service, including those whose first language was not English. People were not supported to access meaningful activities and develop their skills in preparation for discharge.
- The service was not well led. Governance processes had not ensured the delivery of safe and high-quality care. There was no ward manager in the service and the modern matron and general manager were new to their role. Meetings did not effect change; actions were not progressed following meetings. Staff did not feel supported in their role, they were not provided with the training and guidance to provide person centred, individually tailored care.

Due to the nature of our concerns, we have imposed conditions on the provider's registration for this location which prevent the trust from admitting people to the service and require the trust to submit regular updates to CQC on the improvements made.

Culture

People experienced harm because of a lack of protection, they experienced abusive incidents, restraint and seclusion. People had poor relationships with staff which were not therapeutic. Care decisions did not prioritise people's individual needs. People's communication needs were not facilitated.

Our findings

People did not receive person centred care; staff did not have access to the training to provide the knowledge and skills of how best to support people. People were bored and did not have access to meaningful activities including community access to develop their skills and prepare them for the future. People were in hospital for too long. Policies were not in place to progress people's recovery. Including staff training in administering rescue medicine to people to enable them to access the community and people to be involved in self administration of medicines.

There was a lack of visible leadership, staff did not feel listened to, and management failed to act on known issues. People using the service did not see improvements in their care.

Background to inspection

The Assessment and Treatment Service (ATS) has seven beds and is commissioned to provide assessment and support to people with a learning disability or autistic people who are experiencing mental health needs and difficulties with behaviour where other services are not able to meet their needs and keep them safe. There were four people using the service at the time of the inspection.

The service has been registered with CQC since 2013. The service is registered to provide the regulated activities of:

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

There is a nominated individual at the trust with overall responsibility for the service.

The service was last inspected in October 2018 with a rating of good overall and requires improvement in safe. CQC issued requirement notices in relation to induction of staff, staff training in managing aggression and violence. Also, the review of incidents and sharing of lessons learnt. The service had not met all of the actions from the last inspection.

This inspection was an unannounced focused inspection of all the key questions, following concerns raised by the trust's Director of Nursing in March 2021, staff and commissioners.

What people who use the service say

We spoke with two of the people at the service and observed the care being delivered to the other two people at the service using the Short Observation Framework for Inspection (SOFI) observation tool which is a structured way of observing staff interaction with people using the service.

People told us they were bored, they had been at the service too long and spent the majority of their time on their phone, listening to music or watching television. They said agency staff did not know them as well as permanent staff. Everyone was waiting to move to a new placement.

We observed negative engagement with another person at the service of staff not facilitating a request when they asked for a drink and staff talking and laughing amongst themselves rather than engaging with the person. Our observations showed positive engagement of staff playing football with one person at the service and responding to their request of accessing their iPad.

Our findings

We spoke with five relatives. Four relatives were concerned about the care delivered to their relative, they did not feel that staff had the skills or knowledge to meet their needs and did not support their relative to progress and engage in activities they enjoy. Relatives did not feel involved in their relative's care and discharge planning, including multidisciplinary meetings. They did not get regular updates regarding their relative. When the had raised concerns, the service had not responded to them. Relatives told us that staff had been unprofessional and disrespectful regarding their relative, had not safeguarded them from improper treatment and did not support them with activities to develop their daily living skills in preparation for discharge. However, one relative felt involved in their relative's care and received regular updates from the service.

People were not always encouraged to give their feedback about the service. Weekly get together groups should take place to gain feedback from people at the service, however, minutes showed they took place 15 times in 24 weeks. Feedback was being collected individually at the time of the inspection as people found it difficult being in a group together, however we did not see evidence that their feedback was acted upon. One person said they found the ward environment very difficult especially sharing the space with other service users. Minutes showed limited discussion, several agenda items were blank with some actions not being achieved. However, the action of a DVD player was achieved.

Two people regularly completed the feedback form for the multidisciplinary team, prior to the meeting. Topics included activities, recovery goals, mood and feelings. Feedback forms showed that people did not know what their discharge plans were.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- **Safe and clean environment**

People's care and support was provided in a safe, clean, well equipped, well-furnished and well-maintained environment.

- **Safety of the ward environment**

The environment did not meet people's sensory needs. The alarms went off regularly which were loud, several people were autistic, and this may increase people's sensitivity to noise. People told us and records confirmed that they were sensitive to loud noises.

However, staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. Staff had easy access to alarms.

- **Maintenance, cleanliness and infection control**

The service was clean and well maintained with records supporting this. Staff followed infection control policy, including handwashing.

Our findings

- **Seclusion room**

The seclusion room was clean and well maintained with access to natural light and a shower room with toilet.

- **Clinic room and equipment**

One of the oxygen cylinders with the emergency equipment was out of date and the weekly check process had failed to identify the expiry date. Once we made staff aware, they removed the cylinder and added the expiry date to the equipment checklist.

However, clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

- **Safe Staffing**

The service did not have enough staff, who knew the people, and had received relevant training to keep them safe.

There were high levels of vacancies for registered nurses with five whole time equivalent vacancies and one support worker vacancy. Staff turnover for the service was an average of 8% for the 12 months from May 2020. Sickness rates for the service from May 2020 were an average of 10%. Both of these were above the trust's own target.

From November 2020 to May 2021, 82% of registered nurse shifts and 83% of support worker shifts were worked by trust staff, with 169 shifts for registered nurses and 441 for support workers covered by agency staff. The trust did not offer the same training to agency staff as they offered to permanent staff, and this meant that there was a lack of consistent care. Patients told us that agency staff did not know them as well as permanent staff. This meant staff would not have had the same training as permanent staff. There were 15 occasions that shifts were not filled, however there was always a registered nurse on site.

However, there was adequate medical staffing for the service, including out of hours.

- **Mandatory training**

Staff were not appropriately trained for their role. There were low training levels in immediate life support training with 57% compliance; three out of seven registered nurses were not in date with the training. Rotas showed that staff who did not have current immediate life support training worked as the only registered nurse on 17 occasions between January and April 2021. This meant the service did not ensure safe care and treatment during the day and at night. The National Institute for Health and Care Excellence recommends that any setting where restrictive interventions (rapid tranquilisation, restraint or seclusion) are used, people have immediate access to staff trained in life support and to appropriate immediate life support medicine and equipment. Due to the high- risk nature of these interventions.

Other training courses with low compliance were; Deprivation of Liberty Safeguards, medicines management, Mental Health Act and rapid tranquilisation for registered nurses all with 71% compliance; two out of seven registered nurses were not in date with the training.

Our findings

The trust's training for managing violence and aggression was called RESPECT. Level two of the training had 71% compliance; two out of seven registered nurses were not in date with the training. The annual training for RESPECT had 66% compliance, with 10 out of 29 staff were not in date with the training. This placed service users at risk because there were a high level of incidents using restraint in the service and staff were not trained to use these techniques safely. People and relatives told us that they were not moved safely to seclusion.

The trust told us that the mitigation in place for low levels of training was to record how many RESPECT trained staff worked on each shift. The trust's policy stated that there should be three restraint trained staff on each shift. This mitigation was not in place because staff did not complete the handover document in full to evidence that they had enough RESPECT trained staff on to manage incidents of violence or aggression, this meant that people may not be cared for safely.

- **Assessing and managing risk to people and staff**

Two people were not involved in managing their own risks. Staff did not anticipate the risk of supporting a person who had not been out of the service since January 2021, resulting in incidents against staff and the public. Senior leaders did not listen to staff when they expressed concerns about supporting the person in the community again.

People's care and support was not provided in line with their care plans.

Staff told us that reflective practice sessions took place weekly, some staff used this as a debrief following difficult incidents with people. However, records showed they had happened monthly, with four or five people present, usually two were the facilitators.

However, historical and current risks were discussed at handover.

- **Assessment and management of people's risk**

A review of records showed risk assessments were in place with links to the management plan for all people and that these were reviewed.

Staff wore body worn cameras; however, these were not on all of the time, people could ask staff to turn them on. CCTV was not in use in the service.

- **Use of restrictive interventions**

Restrictive practices were not only used as a last resort, for the shortest time and not always in situations where people were a risk to themselves or others.

There were 158 uses of restraint with six people from 1 September 2020 to 1 May 2021. In January 2021 the integrated performance and quality report showed that the service had the highest use of restraint across the trust with 30 incidents, however this had reduced with nine incidents in February 2021, then increased to 23 in March 2021.

Care was not provided in line with care plans. One person had epilepsy which required rescue medicine, non-registered nurses had not been trained in how to administer the medicine which meant the person had been restricted from going out on leave from the service since their admission in January 2021.

Our findings

Another person asked staff for a drink on two occasions and despite having two staff supporting them their needs were not met and they were told “in 10 minutes”. The person was restricted from having food or a drink as they were being cared for in long term segregation and were not able to access food or drink and depended on staff for this.

A review of incidents from 2020 showed for a person who required several staff to access the garden, there were five occasions where they were unable to access the garden due to staffing levels and training of staff. This meant they had to stay in an overly restricted environment.

During the tour of the service, we noted signs saying that remote controls should be locked away and all doors to outside space were locked, people had to ask staff to open them, staff told us people could not be in the garden unsupervised, even though there was a person in the service who was informal and did not have any legal restrictions in place. This was overly restrictive and not individually care planned for the people using the service.

One person was locked in their bedroom or lounge whilst staff cleaned the rest of their flat. This had been added to their risk management plan, however no alternatives for least restrictive approaches had been explored by the service.

The risk register included the blanket restrictions of access to the kitchen and garden area being locked. This did not consider the people on in the service without legal restrictions.

However, the service monitored and reported the use of restrictive practices.

There had been no use of prone restraint, mechanical restraint, one use of rapid tranquillisation and 10 uses of seclusion with four people from 1 September 2020 to 1 May 2021.

- **Safeguarding**

People were not safe from abuse and avoidable harm. Staff did not understand how to protect people from abuse and the service did not work well with other agencies to do so.

Prior to the inspection we were made aware of historical safeguarding incidents involving evidence of harm being caused to people. The service and external organisations were investigating these, but the response was significantly delayed in some cases, because staff had not reported and escalated the incidents.

- **Staff access to essential information**

People’s care records were accessible to staff; however, the creation of the care plans was by the multidisciplinary team with minimal involvement of nursing staff and people receiving care.

- **Medicines management**

People’s medicines were regularly reviewed to monitor the effects of medicines on their health and wellbeing. Staff followed systems and processes to safely store medicines. Staff used the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) to only administer medicine that benefitted people’s recovery or as part of ongoing treatment.

However, there was not always enough information for staff to safely and consistently administer medicines needed to be given when required.

Our findings

People's medicines care and support was not recorded in their care plans.

People did not have care plans in place to indicate how and when to use prescribed as and when required medications. This meant that staff were not always using them in the manner in which they were prescribed.

There was no protocol for people who self-administered their medicines. One person was involved in managing some of their own medicines, however there was no care plan in place to say how this would be done safely.

There was one occasion where a person was staying with relatives and the staff did not arrange for them to take their medicines with them; this meant they did not receive their prescribed medicines.

The service did not consistently monitor and report the use of restrictive practices. Records of incidences of chemical restraint were often incomplete or not in line with prescribed indication.

- **Track record on safety**

The service did not keep people and staff safe. The service did not have a good track record on safety and did not manage patient safety incidents well. Staff did not recognise incidents and reported them appropriately.

In the 12 months from May 2020 there had been three serious incidents including the death of a person being cared for in a general hospital. Prior to the inspection we were made aware of a number of safety incidents that had not been correctly reported and escalated via the trust's incident management system.

- **Reporting incidents and learning from when things go wrong**

Managers did not maintain patient safety and did not always investigate incidents and share lessons learned with the whole team and the wider service.

There were limited opportunities for staff to learn from incidents. Minutes showed that incidents and learning were not discussed at team meetings or the service governance group. The ward manager did not attend the handovers; therefore, communication of actions and updates did not happen to ensure sharing of information about incidents and risks within the service.

However, the trust had a blue light rapid learning notice that they shared with all staff where the incident was summarised, and any learning shared. Incidents and learning were also discussed at the quality assurance committee.

The service apologised to people, and those important to them, when things went wrong. Staff gave honest information and suitable support, and applied duty of candour where appropriate.

There had been two incidents that met the threshold for duty of candour from January 2020. The service apologised to people, and those important to them, when things went wrong. Both incidents were still under investigation at the time of the inspection.

Is the service effective?

Inadequate 

Our findings

Our rating of effective went down. We rated it as inadequate because:

- **Assessment of needs and planning of care**

People's human rights were not upheld by staff who supported them to be independent and have control over their own lives.

Care and support plans were not holistic and did not reflect people's needs and aspirations.

People, those important to them and staff did not develop individualised care and support plans.

The care plans in place were detailed but contained no clear goals or interventions to support discharge. The detail contained within them meant that it was difficult for staff to know how best to support people. People had limited involvement in the creation of the care plans and three relatives told us that they were not involved in the creation of the care plans. Good practice for services caring for people with a learning disability is to create person centred short positive one-page profiles, including the person's strengths and how they like to be supported. The service did not have these in place.

However, assessment of people's needs started at admission. Positive behaviour support plans, communication profiles and sensory assessments were in place. Two relatives told us they were involved in the assessments of their relative and shared how best to support them.

- **Best practice in treatment and care**

Care and treatment did not focus on people's quality of life outcomes and did not meet best practice. Care and support was not provided in line with people's positive behaviour support plan and care plans.

We observed during the inspection that staff did not tell a person who was sensitive to loud noises that a fire alarm test was going to take place. We also observed staff did not meet the request when a person asked for a drink. Staff did not support verbal communication with the use of Makaton for a person assessed as needing this communication method.

Activities were not meaningful and did not focus on skill development for future placements. We reviewed the activity records and observations records for last two weeks of April 2021, people told us, and records confirmed that two people spent the majority of the time in their rooms, on their phones and listening to music. For one person their sensory assessment from October 2019 identified three activities and pieces of equipment that would be beneficial for them, however staff had not facilitated this.

Each person had recovery goals in place, however these did not focus on skill development, they were leisure activities including singing, walking and art and craft. This was not appropriate for this type of service where the role of the service is to provide assessment and treatment.

Staff did not complete clinical audits, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care.

However, for the person with epilepsy that required rescue medicines, there was an individually tailored care plan in place and seizure and rescue medicine guidance for staff to follow.

People had access to a range of psychological assessments.

Our findings

Information in the service was available in accessible form; there were pictorial menus, symbols on doors and pictures of the staff team.

People had good access to physical healthcare.

- **Skilled staff to deliver care**

The service was for people with a learning disability or were autistic, however staff had not had training in learning disability, communication skills and epilepsy. This meant staff did not have the knowledge and skills of how best to support people. Staff had received training in an introduction into autism however the information in the training was not current.

However, managers provided an induction programme for any new or temporary staff. Staff had regular supervision and appraisal.

- **Multidisciplinary and interagency teamwork**

People were not supported by a team of staff from a range of disciplines who worked well together to ensure care was delivered and outcomes achieved in line with care and discharge plans. The senior therapists in the service were not visible and their impact was not evident.

Staff told us and we observed there was a divide between the multidisciplinary team and the nursing team. Care plans were written by the multidisciplinary team with little input from the nursing team.

Relatives told us, and we observed that members of the multidisciplinary team could be disrespectful during the meetings, one staff member rolled their eyes when another professional was talking. Relatives told us that a staff member laughed when they shared their concerns about a geographical area proposed for their relative's discharge.

There was little management oversight at multidisciplinary reviews. Staff told us that historically the ward manager would attend the multidisciplinary reviews, partly due to staffing as there needed to be a registered nurse in the service and records confirmed there were several occasions where there was just one registered nurse on shift so they would not have been able to attend the meeting.

However, care coordinators told us that staff were responsive to the requests for information that they made, and they were involved in the multidisciplinary reviews.

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

Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.

- **Good practice in applying the Mental Capacity Act**

People were supported to make decisions about their care. Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards. For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions.

Our findings

Is the service caring?

Inadequate ↓↓

Our rating of caring went down. We rated it as inadequate because:

- **Kindness, privacy, dignity, respect, compassion and support**

People did not always receive kind and compassionate care.

We saw examples of staff not responding to people's needs; when they asked for a drink staff said in 10 minutes and staff talking and laughing amongst themselves rather than engaging with the person. Another occasion when a person in segregation was being animated and trying to engage with staff, staff did not enter the segregation area to spend time with the person, they sat in the corridor.

Members of the multidisciplinary team said they were unable to communicate with one person where the sensory room was and the person had not visited the sensory room, despite this being an aim of their positive behaviour support plan.

However, some people received kind and compassionate care. Staff protected people's privacy and dignity and understood some people's needs. People spoke highly of staff and the care they received.

- **Involvement in care**

People, and those important to them, did not always take part took part in making decisions and planning of their care. People were not always empowered to feedback on their care and support.

Staff told us that weekly get together groups should take place to gain feedback from people at the service. However, minutes showed that did not always happen, they took place 15 times in 24 weeks. Minutes showed limited discussion, several agenda items were blank with some actions not being achieved. However, the action of a DVD player was achieved. One to one sessions only took place with two people who used speech to communicate. There was no involvement in the care from people who used limited speech and other form of communication.

Staff also collated individual feedback from people prior to multi-disciplinary meetings and two people regularly completed the feedback form prior to the meeting. Topics included activities, recovery goals, mood and feelings. However, feedback forms were not effective. They showed that people did not know what their discharge plans were, and several issues were being raised for several weeks without being resolved.

However, two people took part in making decisions and planning of their care. People were empowered to feedback on their care and support.

An accessible welcome booklet was given to people to explain about the service and the staff supporting them.

- **Involvement of people**

People had access to independent advocacy. Staff supported people to maintain links with those that are important to them. Advocates told us that staff facilitated the visits and were responsive to issues raised and involved them in meetings and decision making.

Our findings

Staff maintained contact and shared information with those involved in supporting people, as appropriate.

- **Involvement of families and carers**

The service did not ensure that those important to people using the service took part in making decisions and planning of their care.

We spoke with five relatives. Four relatives were concerned about the care delivered to their relative, they did not feel that staff had the skills or knowledge to meet their needs and did not support their relative to progress and engage in activities they enjoy. Relatives did not feel involved in their relative's care and discharge planning, including multidisciplinary meetings. They did not get regular updates regarding their relative. When they had raised concerns, the service had not responded to them. Relatives told us that staff had been unprofessional and disrespectful regarding their relative, had not safeguarded them from improper treatment and did not support them with activities to develop their daily living skills in preparation for discharge.

We observed two people's multidisciplinary reviews and relatives were not involved in these meetings.

However, one relative felt involved in their relative's care and received regular updates from the service.

We observed families visiting people at the time of the inspection.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- **Access and discharge**

The length of admissions did not adhere to NHS England's publication "Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition" which states "Services should seek to minimise patients' length of stay and any admissions should be supported by a clear rationale of planned assessment and treatment with measurable outcomes."

- **Bed management**

There were four people at the service. The service provided care to people within the local area and for people from outside the local area. However, due to the concerns the trust had raised about the service, the trust had agreed not to admit any more people currently.

- **Discharge and transfers of care**

People stayed in hospital for a long time. People did not have discharge plans with clear timeframes in place to support them to return home or move to a community setting. There were four people at the service, one person had been at the service for 23 months, another 22 months, another 17 months and the shortest length of stay was four months. All people were waiting for community placements.

Our findings

Staff told us and records confirmed that an assessment identifying recommendations for future placements was not created as part of the admission. This meant that discharge plans were unclear and disjointed, there was one person where the service's view on the discharge plan was different from that of the care coordinator. We observed tensions and communication difficulties with another person's future support provider which indicated that discharge planning was poor for this person

Care coordinators and relatives told us that at times they felt the service was not planning a safe discharge, as they were not preparing people for discharge by supporting them to access the community and develop skills In preparation for discharge, including daily living skills.

- **Facilities that promote comfort, dignity and privacy**

The service's design, layout and furnishings did not ensure people's good care and support.

The activity room in the service did not have any tables within it, it had an exercise bike in the room, with a variety of resources in cupboards, people told us, and we observed that the room to do activities at a table had moved upstairs which made it difficult for people to access.

People could not access drinks and snacks at any time. There were drinks flasks and drink making equipment in both the lounges however this was behind a locked door, people were not able to make themselves drinks and snacks unsupervised. People had to ask staff to make them a drink or be able to access the kitchen.

For one person their sensory assessment from October 2019 identified three activities and pieces of equipment that would be beneficial for them; the use of the bubble wand and musical instruments was not successful and the egg chair had not been provided.

However, staff respected people's privacy and dignity. Each person had their own bedroom with an en-suite bathroom. People could personalise their room and keep their personal belongings safe. People had access to quiet areas for privacy.

The service provided people with a choice of good quality food which was tailored to people's cultural and dietary preferences. There were menus in accessible format on display and laminated for ease of use.

- **Peoples' engagement with the wider community**

Although staff told us that they had supported people to access community activities in the past, at the time of inspection people were not accessing the community regularly. We reviewed activity records for the last two weeks of April 2021 and the first week of May 2021 and found that activities offered to people were not therapeutic or recovery and discharge orientated, they were; iPad, spending time in the garden, watching TV, football in the garden, baking, craft, making hot chocolate, listening to music, playing pool, shopping, visiting the car park, vaping, washing up, dentist appointment, out with community team, a visit from future support team and visits from relatives.

- **Meeting the needs of all people who use the service**

The service did not meet the needs of all people using the service, including those with needs related to equality characteristics. People's communication needs were not always met.

Our findings

One person's first language was not English, and they did not have regular access to an interpreter. Another person used Makaton to communicate and staff were not trained in this communication method. This meant that staff were not able to fully understand people's needs.

However, staff helped people with advocacy, cultural and spiritual support.

There was an introduction to the service in easy read format and easy read information available for medicines.

- **Listening to and learning from concerns and complaints**

People, and those important to them, could not raise concerns and complaints easily. One person and relative thought they needed to complete a complaints form to complain. Relatives told us they had complained however did not receive an outcome or response from the service. These complaints were not included in the numbers shared by the trust. Therefore, these were not investigated, and learning was not shared with the whole team and the wider service.

The service recorded no complaints from May 2020 to May 2021.

The service did not encourage people to give feedback and was not responsive if people raised concerns.

However, there had been four compliments from May 2020 to May 2021 from people and their relatives about the care received.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

- **Leadership**

Leaders did not have the skills, knowledge and experience to perform their roles and understand the services they managed.

The leadership of the service was disjointed at the time of the inspection. The ward manager was absent from the service, and the deputy ward managers were leading the shifts and at times had also been the only registered nurse on shift, therefore they had limited time to provide managerial support.

In order to support the service, the trust had appointed a new modern matron and general manager. They had only received a brief induction.

- **Vision and strategy**

Service managers did not have a vision for the service and for each person who used the service. Senior leaders had not been visible in the service and approachable for people and staff.

The service did not have a clear standard operating procedure.

Our findings

The trust were writing their revised strategy at the time of the inspection.

The trusts vision was:

“Our vision is to improve the mental, physical and social wellbeing of the people in our communities.

We will do this by:

- Working with and advocating for the local population
- Refocusing our services towards prevention and early intervention
- Continuous improvement of our services
- Locating services as close to peoples’ homes as we can
- Developing a confident and skilled workforce
- Ensuring excellent and sustainable services”

The trust values are:

- Respect – we listen to others, valuing their views and contributions.
- Compassion – we show empathy and kindness to others so they feel support, understood and safe.
- Partnership – we engage with others on the basis of equality and collaboration.
- Accountability – we are open and transparent, acting with honest and integrity, accepting responsibility for outcomes.
- Fairness – we ensure equal access to opportunities, support and services.
- Ambition – we are committed to make a difference and helping to fulfil the hopes and aspirations of our service users and staff.

The service was not applying them in the work of their team because the care and treatment delivered to people was not in line with the vision and values of the trust.

- **Culture**

Staff did not feel respected, supported and valued. There was a lack of visible leadership, staff did not feel listened to, and management failed to act on known issues.

The “Lets Talk Safety” a service publication in March 2020 said that staff had raised concerns about the culture of the service. Actions from the feedback included additional staff to release staff to attend relevant training, how to speak up and further discussion and away days about the culture of the service. Team meeting minutes showed that these actions had not been discussed or achieved.

There had been two grievances in the service from May 2020 to May 2021. There had been 10 disciplinary incidents since 1 May 2020 including four of a breach of professional boundaries between staff incidents were under review or had been resolved informally.

Our findings

However, results from the staff survey showed that the majority of the answers to the questions were positive. The questions that had a higher negative answer were that there were problems with safety of people in the service and violence from people using the service and staff put themselves under pressure to come to work.

- **Governance**

Our findings from the other key questions showed that governance processes did not help to keep people safe, protect their human rights and did not provide good quality care and support.

Although the trust had identified concerns in March 2021, actions taken did not deliver the rapid improvement to address the concerns prior to our inspection, despite feedback from other external stakeholders.

The trust had also failed to take rapid action following the concerns we raised following our initial inspection visits on 28 and 29 April 2021. On 30 April 2021 we wrote to the provider to identify areas of poor practice we had identified and required assurances regarding safety of the service.

The service created an action plan in response .We completed an inspection visit on 10 May 2021 to follow up on the trust's action plan and found that the actions that should have been completed had not been completed. We were also concerned that the action plan was not created in collaboration with the leaders within the service.

There had been a number of missed opportunities for leaders to take action where concerns were raised about the service prior to our inspection.

The service had shared a "Lets talk safety" document with staff dated 1 April 2021 to thank the staff team and update them on staffing, blue light safety alerts and performance. This included service users saying they were bored and would like more activities; however, no action had been taken regarding this.

Monthly governance meetings took place for the service with a comprehensive agenda of safe, effective, caring, responsive and well led. A number of concerns were noted in these meetings which were not acted upon. For example, in January 2021, mandatory training compliance was discussed, particularly that low levels for RESPECT were a concern however there was not action to address this.

There was poor oversight of the use of body worn cameras. At the governance meeting in January 2021 actions were identified including explaining to people the purpose of the cameras and training for staff, however the actions were not reviewed at the next governance meeting in March 2021. This meant leaders and managers were not acting on concerns to improve the quality of the service.

- **Management of risk issues and performance**

The service had a risk register which included the recent concerns raised about the service, however no action had been taken to reduce the risks. Risks included recruiting the right staff, environmental issues, risk of injury to staff, impact of COVID19 on the service, some risks have not been updated since January 2021.

However, we saw evidence that leaders had sometimes used data to identify concerns about the service.

Our findings

The trust had monthly Integrated Performance and Quality Reports which included the service if there was relevant data. The January 2021 report showed the service had the highest rates of restrictive practice. Monthly quality reports were completed which included analysis of incidents and showed a reduction in the use of rapid tranquillisation in March 2021

- **Information management**

The service did not create clear recommendations from the service to commissioners and care coordinators.

However, staff had the information they needed to make informed decisions on treatment options.

- **Engagement**

The service did not ensure that people, and those important to them, could work with managers and staff to develop and improve the service. The provider did not always seek feedback from people and those important to them and used the feedback to develop the service.

Relatives and external professionals told us that the communication from the service was poor, both in providing updates externally on how people were doing and to the nursing team regarding actions and agreements from meetings.

The trust did not work together with the local authority to ensure safeguarding concerns were reported and investigated.

- **Learning, continuous improvement and innovation**

Staff did not engage in local and national quality improvement activities.

Our findings

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that there are sufficient trained staff to administer rescue medicines for epilepsy.(Regulation 18 (1) (2) (a))
- The service must ensure that care plans and risk assessments are available for self-administration and when required medicines. (Regulation 12 (2) (g))
- The service must ensure that medicine administration records are completed in full and that when required medicines are used for the prescribed purpose. (Regulation 12 (2) (g))
- The service must ensure that staff receive training relevant to their role including in immediate life support, RESPECT, learning disability, autism, communication skills and epilepsy.(Regulation 18 (1) (2) (a))
- The service must ensure that care delivered is in line with people's care plans and is least restrictive.(Regulation 9 (1) (b))
- The service must ensure that care plans are developed with people at the service and their families and include clear goals and what people need to do to achieve the goals. (Regulation 9 (1) (3) (a) (b) (d))
- The service must ensure that it supports people to pursue meaningful activities that relate to their recovery and discharge planning. (Regulation 9 (1) (b) (3) (b))
- The service must ensure that they meet people's communication needs, including accessing interpreters and providing training to staff. (Regulation 9 (1) (b) 3 (h))
- The service must ensure that each person has an individualised discharge plan with timescales in place which has been co-produced with each person, their family or carers and all professionals involved in their care. The service must ensure that it supports people to pursue meaningful activities that relate to their recovery and discharge planning. (Regulation 9 (1) (b) (3) (b) (c) (d) (f))
- The service must ensure there are policies and guidance in place regarding the use of medicines and people self-administering their own medicines. (Regulation 17 (1))
- The service must create a standard operating procedure for the provision of care to all people from the multi-disciplinary team. The standard operating procedure must also include the registered provider's expectations on the training and skills required by all staff working at the service. (Regulation 17 (1))
- The service must ensure they have oversight of incidents and safeguarding concerns, investigating these and sharing lessons learnt with staff and reporting these to statutory organisations where required. (Regulation 17 (1))

Action the service SHOULD take to improve:

- The service should consider the impact of the alarms going off regularly on people who are sensitive to noise.
- The service should review the activity room facilities to ensure it is accessible to people in the service.

Our findings

- The service should review how they share lessons learnt with the staff team to ensure staff understand these and how to implement them in practice.
- The service should review how they share with staff how best to support people and consider the use of one-page profiles.
- The service should review the communication process between the multidisciplinary team and nursing team to ensure progress and actions are shared and all members contributions are listening to and valued.
- The service should ensure that people know how to complain, and if people do complain, investigate their concerns, share the outcome and any lessons learnt with both the complainant and staff team
- The service should review the surveillance they use in the service, including the use of body worn cameras, to ensure it is used for the right purpose, and consider the use of CCTV.

Our inspection team

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about the location and asked commissioners for information. We used the Quality of Life tool in the planning of this inspection.

During the inspection visit, the inspection team:

- Visited the service and observed how staff were caring for people.
- Toured the service and clinic room.
- Spoke with two of the people at the service and observed the care being delivered to the other two people at the service on four occasions using the Short Observation Framework for Inspection (SOFI) observation tool which is a structured way of observing staff interaction with people using the service.
- Spoke with five relatives.
- Received feedback from two independent advocates and four care coordinators.
- Spoke with nine support workers, three registered nurses, the clinical psychologist, consultant psychiatrist, modern matron, occupational therapist, speech and language therapist and the general manager.
- Observed three handovers.
- Looked at four care and treatment records of people and Mental Health Act documentation and seclusion and long-term segregation records for two people.
- Looked at a range of policies, procedures and other documents relating to the running of the service including rotas and observation records.

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

This section is primarily information for the provider

Enforcement actions

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 Diagnostic and screening procedures 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 Diagnostic and screening procedures 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing