Cygnet Yew Trees

Quality Report

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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?	Good
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.

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

Summary of findings

Overall summary

Our rating overall went down. We rated Cygnet Yew Trees as 'requires improvement' because:

- The provider's governance systems did not always sufficiently assess, manage and mitigate risks for the hospital. Improvements were needed to safeguard patients. For example, the provider had not made thorough checks to ensure agency staff were suitable to work with patients. The provider had not clearly identified protection plans to detail the actions staff needed to take to ensure vulnerable adults were safe following incidents. The provider's policy did not give clear information to staff about these areas. The provider's governance systems did not show how they were monitoring and assessing the use of staff restraint with patients and taking action to reduce them.
- The provider had not always ensured that staff were completing accurate records of their observations of patients which posed a risk to patients' safety.
- The provider's staff recruitment and retention processes were not fully effective as there were 11 nursing vacancies and there was 27% staff turnover. There were 33 occasions (39%) over a six-week period when there was less than 50% female staffing to support patients' needs.
- The provider had not ensured that the manager had sufficient training for their role as a leader. The provider had not ensured staff always received regularly supervision as per their standard.
- The provider's discharge processes were not fully effective. Patients stayed longer at the service 782 days, an increase since our last inspection in June 2017 (408 days) and above the national average (554 days). There were five patients with delayed discharges when we visited.
- The provider had not completed a specific assessment of how they were meeting the accessible information standards- in line with section 250 of the Health and Social Care Act 2012.
- The provider was unable to show their compliance with reporting requirements for the Workforce Race Equality Standard.

However:

- Staff were creative and had developed a variety of ways to help patients non-verbally communicate their needs and choices and express how they were feeling. This had empowered patients and helped them not to be reliant on staff. Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They 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 involved patients in care planning and risk assessment and actively sought their feedback on the service provided.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with a learning disability.
- The ward teams included or had access to a range of staff required to meet the needs of patients on the wards. Managers ensured that these staff received training and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. Staff we spoke with felt respected, supported and valued.

Summary of findings

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Background to Cygnet Yew Trees

The location Cygnet Yew Trees is a 10-bed hospital for women aged 18 years and above who have a learning disability. The provider for this location had changed in May 2019 to Cygnet (OE) Limited.

This location was registered with the Care Quality Commission on 27 November 2012 for the following regulated activities:

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

The location has a registered manager and a controlled drugs accountable officer.

The Care Quality Commission previously carried out a comprehensive inspection of this location on 6 June 2017. The location was rated overall as 'good. There were not any identified breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, at this inspection we have identified a breach of Regulation 12 safe care and treatment.

Our inspection team

The team that inspected this location comprised of a CQC inspector; an assistant inspector; a specialist advisor nurse with experience of working with patients with a learning disability and an expert by experience someone with experience of caring for someone who uses health and/or social care services.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and 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 organisation for information.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with three patients who were using the service;
- spoke with six carers;
- spoke with the registered manager;
- spoke with five other staff members; including a doctor, nursing staff, therapy staff and a psychologist;
- gained feedback from two independent advocates;
- looked at six care and treatment records of patients;
- observed four episodes of staff supporting patients;
- carried out a specific check of the medication management;
- looked at a range of policies, procedures and other documents relating to the running of the service, and

Summary of this inspection

- looked at three staff personnel files and eight agency staff records.

What people who use the service say

We communicated with three patients using the service. They communicated to us that overall, they were satisfied with the service. They liked living at the hospital, the staff and activities. They gave examples where staff had involved them in their care. However, the patients communicated that the hospital was noisy at times and they did not like patients getting angry and shouting.

We spoke with six carers of patients. Overall, they were very satisfied with the service and said that staff treated their relative well. They told us staff knew their relative's needs and gave the right support. They said staff had involved them in their relative's care and kept them updated about any changes. Two said staff encouraged their relative with healthy eating.

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 safe went down. We rated it 'requires improvement' because:

- The provider had not ensured effective systems were fully in place to safeguard patients. For example, the provider had not made thorough checks to ensure agency staff were suitable to work with patients. We checked eight agency staff records and found gaps in training and disclosure and barring service records. The provider had not clearly identified protection plans to detail the actions staff needed to take to ensure vulnerable adults were safe following incidents. The provider's policy did not give clear information to staff about these areas.
- The provider had not always ensured that staff completed accurate records of their observations of patients which posed risk to patients' safety. We checked a sample of observation records for three patients and found gaps in two patients' records, which could pose a risk staff were not adequately observing patients.
- The provider's governance systems for oversight or monitoring of staff restraint with patients were not robust. The provider had reported 693 episodes of restraints between 31 March 2018 and 31 March 2019 but did not monitor these to identify if this posed a risk to the organisation or patients in line with their 'Safe Use of Restrictive Interventions Physical Restraint Policy'.
- The provider's staff recruitment and retention processes were not robust as there were 12 vacancies and 27% of staff turnover. The provider had to use agency staff to cover the shortfall. There were 33 occasions (39%) over a six-week period when there was less than 50% of female staffing. This could pose a risk of staff not being available to support patients with their personal care needs.

However:

- Staff compliance with essential training as identified by the provider was 100%. The provider had ensured that permanent, bank and regular agency staff had completed training to be able to safely use de-escalation or restraint techniques with patients.
- Staff had introduced a social skills group for patients and were completing debriefs with patients to help reduce the number of incidents.

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- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with a learning disability).

Are services effective?

Good

Our rating of effective stayed the same. We rated it as 'good' because:

- Staff were creative and had developed a variety of ways to help patients non-verbally communicate their needs and choices and express how they were feeling. This had empowered patients and helped them to be self-reliant.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The provider had access to a range of specialists required to meet the needs of patients at the hospital. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- 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.

However:

Summary of this inspection

- The provider had not ensured all staff received regular supervision as per their standard of six times in 12 months.
- Staff were using but not recording their ratings of patients on the' National Early Warning Score' a tool developed by the Royal College of Physicians to improve staff's detection and response to patients' deterioration and know when to refer patients to hospital or their GP.

Are services caring?

Good

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and patiently supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the service provided. They ensured that patients had easy access to an independent advocate.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as 'good' because:

- Staff helped patients with communication, advocacy and spiritual support.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Patients had been involved in choosing the new pink decoration of ward walls, with some butterflies and flowers.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- The providers' discharge processes were not fully effective as patients stayed longer at the service including 782 days which was an increase since our last inspection in June 2017 (408 days) and above the national average (554 days). There were five patients with delayed discharges when we visited.
- The provider had not completed a specific assessment of how they were meeting the accessible information standards- in line with section 250 of the Health and Social Care Act 2012.

Summary of this inspection

Are services well-led?

Requires improvement 

Our rating of well led went down. We rated it 'requires improvement' because:

- The provider's governance systems did not always sufficiently assess, manage and mitigate risks for the hospital. The provider's safeguarding policy needed updating for agency staff checks, staff training, and protection plans, and they had not ensured there was sufficient oversight of safeguarding vulnerable adults processes.
- The provider's systems for ensuring staff recorded their observation of patients was not robust as we found gaps in records.
- The provider's governance systems did not show how they were monitoring and assessing the use of staff restraint with patients across the hospital and taking action to reduce them.
- The provider had not ensured that the manager had sufficient training for their role, such as for leadership.
- The provider was unable to show their compliance with reporting requirements for the Workforce Race Equality Standard.

However:

- Leaders were visible in the service and approachable for patients and staff.
- Staff we spoke with felt respected, supported and valued. They felt positive and proud about working for the provider and their team.They felt able to raise concerns without fear of retribution.
- Managers and staff had access to the feedback from patients, and staff and used it to make improvements. Patients and staff could meet with members of the provider's senior leadership team to give feedback.
- The doctor and psychologist held quality assurance 'walk arounds' the ward to offer staff the chance to raise any concerns or issues they needed assistance with to make changes.

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.

- All patients were detained under the Mental Health Act 1983/2007 when we visited. One hundred percent of staff 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.
- The Mental Health Act administrator oversaw the Mental Health Act paperwork and audited this regularly to make sure it met legal requirements, was up to date and stored appropriately. The latest provider's audit of processes and records 12 September 2018 showed 99% compliance.
- The provider had relevant policies and procedures for staff to follow and these were being updated by the new provider following the merger. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.
- Patients had easy access to easy read information about independent mental health advocacy. The advocate had received two referrals from the site since July 2018.
- 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.
- Staff ensured that patients were able to take section 17 community leave and were assessed before they went out.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There were no patients subject to Deprivation of Liberty Safeguards authorisations when we visited.
- Ninety four percent of staff had had training in the Mental Capacity Act.
- Staff had a good understanding of the Mental Capacity Act, in particular the 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 had access to it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff took all practical steps to enable patients to make their own decisions.
- 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.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- The service had arrangements to monitor adherence to the Mental Capacity Act.
- Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it. The latest provider's audit of processes and records on 24 October 2018 showed 99% compliance.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- All areas of the ward were clean and tidy. All furnishings were in good condition and well maintained. We saw examples of staff reporting maintenance issues. However, staff carried out visual daily environmental risks assessments of the ward but were not recording these.
- The layout of the hospital did not allow staff to observe all areas of the ward. The hospital was an old residential property that had been adapted for its current use. The provider had installed mirrors to reduce the risk from blind spots. Staff would increase a patient's observation level, following a risk assessment if they were concerned they were at risk of harm to themselves. The provider had close circuit television in communal areas.
- We did not identify any concerns relating to the provider's ligature risk assessment at this inspection. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation). The provider had completed a risk assessment and staff completed individual risk assessments of patients.
- As the hospital was for women only the provider complied with the Department of Health guidance for eliminating mixed-sex accommodation.
- The clinic room was equipped with all necessary equipment for monitoring patients' physical health. Staff kept resuscitation equipment in a cupboard in the staff office, so it was easily accessible to all staff when needed.
- Staff adhered to infection control principles. There were hand-washing facilities, including alcohol disinfectant gel.
- Staff had alarms they could use to summon assistance in an emergency.
- Staff had personal emergency evacuation plans for patients.

Safe staffing

- The provider's staff recruitment and retention processes were not robust. The provider's staffing establishment was: four nurses and 41 support workers. At our visit the provider had four nurses and 27 support workers in post. They still had vacancies including: one nurse vacancy (a reduction from our 2017 inspection) for a deputy manager post, ten support workers (an increase from our 2017 inspection) and one activity coordinator. Additionally, the provider had recruited an occupational therapist due to start imminently.
- Managers had calculated the number and grade of nurses and support workers required.
- When we visited, the provider's standard was to have one nurse and 10 support workers on duty during the day shift, 07:00 to 19:30 hours and one nurse and seven support workers during the night shift, 19:00 to 07:30 hours.
- When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Data from the provider showed they had used agency staff to cover 611 shifts and bank staff (employed by the provider on

an as and when basis) to cover 44 shifts, 30 September 2018 to 31 December 2018. There were five occasions (6%) when they were unable to get cover and staffing was below the provider's baseline number. In December 2018 the provider was using 50% agency nurses. When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. All agency staff nurses booked were block booked to give consistency and had worked for the provider for the last year. The manager had identified seven occasions staffing fell below the provider's baseline number in the last six weeks of our visit. The manager stated this was mainly because agency staff cancelled shifts at short notice. They stated this had not affected patients' safety or staff's observation of patients. However, there were 33 occasions (39%) over a period of six weeks when there was less than 50% female staffing. This could pose a risk of staff not being available to support patients with their personal care needs.

- The provider had a recruitment plan and were trying to recruit staff with social media adverts and using media publications. The provider had managed to recruit two new nurses in January 2019.
- As of 10 May 2019, there was 27% staff turnover (for the previous 12 months a reduction since our 2017 inspection but more than the NHS at 13-15%). Seven support workers, an occupational therapist, a nurse and an activity coordinator had left. The manager said there was no apparent themes for this and outlined reasons for staff leaving such as career progression, wanting to work with a different patient group.
- There was enough staff, so patients could have regular one-to-one time with their named nurse. Patients told us that staff were always available and would make time to speak to them when required.
- The provider rarely cancelled escorted leave or activities due to lack of staff. Staff and patients told us that they would only cancel leave or activities due to exceptional circumstances.
- There was sufficient staff to safely carry out restraints with patients.
- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The provider employed two consultant psychiatrists, who worked across three of the provider's hospitals locally. Out of hours there was an on call doctor system for the hospital). If there was a medical emergency staff would call an ambulance.
- Staff had received and were up to date with mandatory essential training as identified by the provider. As of 30 April 2019, there was 90% compliance and following the inspection the provider sent us information on 10 May 2019 to show staff compliance with training was 100%.

Assessing and managing risk to patients and staff

- The provider had not always ensured that staff were completing accurate records of their observations of patients which posed risk to patients' safety. We checked a sample of observation records for three patients and found gaps in six records for two patients where staff had not recorded their checks. The manager said some patients had reduced staff observations at night which was agreed with the patient and commissioner. However, the staff's observation records checked did not clearly detail this and instead showed a requirement for staff to check patients every 60 minutes. There was not information to show staff checked on a patient for a nine hour period. The provider had a coding system for staff to use but this was not always used. Some records held minimal information to indicate staff made thorough checks to ensure the patient's safety. For example, on 3 April 2019 a staff member had recorded at 01:00 hours that they were 'unable to open bedroom door to check' on a patient and the next recorded staff check on the patient was three hours later. Other examples included where staff had documented 'appears asleep in bed' or there was no activity recorded. The manager said the provider did not complete specific audits of observation records but were planning on using a new tool for this. They said records were shared with commissioners of the service. We saw the manager had informed staff in team meetings about the level of observation required for patients. Staff reviewed the level of observations required for patients at multi- disciplinary meetings.
- The provider had reported a lot of staff use of restraints with patients. Between 31 March 2018 and 31 March 2019 staff had reported 693 episodes of restraint which had involved 11 different patients. These included 287 incidents of staff using breakaway techniques, 237 wrap or escorts techniques, 98 floor restraints, 55 were seated holds and 16 guided techniques. There were no episodes of prone restraint (facedown). The manager was not able to give assurance that the provider was monitoring the amount of restraints to identify if this was outlier or posed risk for the organisation or patients,

as outlined in the provider's 'Safe Use of Restrictive Interventions Physical Restraint Policy'. Staff said they only used restraint if de-escalation was unsuccessful. Staff explained to us where they had reduced the use of restraint with patients. Staff documented in patients' positive behaviour support plans information on triggers and de-escalation techniques for use with individual patients as well as information on how patients prefer to be restrained. Staff reviewed individual patients' incidents at multi-disciplinary team reviews with patients. They had gained feedback from patients about their experience of being restrained and had shared this with staff via a poster displayed in their boardroom. The manager discussed restraint incidents with staff at team meetings and reminded staff to use restraint as a last resort. The provider had ensured that permanent, bank and regular agency staff had completed training to be able to safely use de-escalation or restraint techniques with patients. The provider had completed a 'safer physical intervention' audit in August 2018 which showed an overall 83% compliance for the location.

- The provider did not have a seclusion room and did not use seclusion or segregation as an intervention.
- We checked six patients' care and treatment records. Staff used the providers risk screening and assessment tool to assess risks to patients on admission and reviewed them in multi-disciplinary meetings. The tool covered a range of risks, such as violence and aggression, suicide, self-neglect and self-harm.
- Staff applied blanket restrictions on patients' freedom only when justified. Staff gave an example where recently they had introduced a system to ensure patients had access to snacks and drinks which also promoted healthy eating.

Safeguarding

- The provider did not have fully effective systems in place to safeguard patients. The policy staff used did not clearly give information relating to agency staff checks, staff training, and protection plans. Despite incidents of alleged abuse involving some staff, the provider had not always checked that staff had safeguarding vulnerable adults training for their role. We checked eight agency staff records and found there were gaps. For example, four of five records for one agency did not show that staff had completed safeguarding adults training. The manager contacted the agency who later provided information). Nursing agency profiles of staff stated 'disclosure and barring service' (DBS) checks had been made but only one stated it was enhanced (it is a requirement for healthcare workers to have enhanced with an adults' barred list check). This was despite the provider requesting checks of this and a record stating the action was completed 21 October 2018. Agencies provided risk assessments of staff if a conviction was identified during checks, but this did not give adequate assurance that they had assessed if there were any risks to vulnerable adults. However, the provider sent us information after the inspection to show they had ensured staff from one agency had an enhanced DBS checks. The provider sent us information after the inspection stating that when we visited the Danshell policy was in place and the Cygnet policy was being adopted which incorporates protection plans.
- The provider had not ensured sufficient oversight of safeguarding processes at this location as the CQC identified that the provider had not always been following their safeguarding policy for example to notify the police of relevant incidents. Following this feedback the provider stated they had taken action to address this. Following an incident the manager had identified that staff were not always confident about their role and responsibilities relating to safeguarding vulnerable adults and knowing how to report concerns. The manager had arranged for registered staff to complete level three safeguarding training and they arranged additional training for staff. Ninety seven percent of staff had completed the provider's safeguarding adults and children training. Managers were booked to attend level four safeguarding training. Staff we spoke with knew how to make a safeguarding alert. We saw examples where staff had appropriately reported safeguarding concerns for investigation.
- The provider had not clearly identified protection plans to detail the actions staff needed to take to ensure vulnerable adults were safe and supported following incidents. Whilst staff explained actions they would take to keep patients safe, this information was held in various parts of the patients' care records and was not easily identifiable.
- The provider had completed a safeguarding audit with patients in October 2018 and an action plan was developed from any feedback. Staff had introduced a

social skills group for patients and staff considered this was helping reduce the number of patients on patient incidents and were looking to review their data to evidence this.

Medicines management

- Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. However, staff had not disposed of insulin which was used four weeks previously and was left in the fridge but did this when we brought it to their attention.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication. The provider had systems for stopping over medication of people with a learning disability, autism or both with psychotropic medicines (STOMP). This national project involves different organisations helping to stop the over use of these medicines. Staff had developed information for patients about their medication in an easy read format.

Track record on safety

- The provider gave conflicting information about the number of serious incidents that had occurred in the service. They stated before our inspection there had not been any serious incidents between 1 March 2018 to 1 March 2019. However, we found reference to serious incidents in unit led clinical governance meeting minutes. We asked the provider for more details on this and they stated there had been four serious incidents in the last 12 months before our inspection. This included the two we saw when we visited that were currently being investigated.

Reporting incidents and learning from when things go wrong

- We saw examples where staff had reported incidents and reviews had taken place to reduce the risk of reoccurrence.
- The provider had ensured that staff received feedback from incident investigations of incidents in various ways. For example, staff had telephones which gave them email updates on reported restraints and incidents. Staff received emails following feedback and the manager discussed incidents and any learning at team meetings. Individual incidents for patients were reviewed at multi-disciplinary team meetings and the manager had developed a folder for staff to easily refer to the discussions and actions if they could not attend.
- The psychologist had collated data about individual patient's incidents including themes to analyse possible reasons/causes for the behaviours. They gave staff supervision session for patients that presented with complex behaviour to help them in their care and treatment of the patient.
- The manager had also developed a ' purple folder' which captured debriefs with staff and patients following incidents. Staff carried out debriefs with patients using a pictorial easy read form. They had carried out 18 in April 2019, (although not all were fully completed).

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We checked six patients care and treatment records. Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission.
- Staff assessed patients' physical health needs in a timely manner after admission.
- Care plans were personalised, holistic and recovery-oriented.
- Staff updated care plans when necessary. However, staff had not updated a patient's assessment to show that they no longer needed a specialist epilepsy assessment.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.
- Staff ensured that patients had good access to physical healthcare, including access to specialists when

needed, such as for diabetes. Staff developed health action plans and hospital passports easily identifying patients' physical health needs. Patients were registered with a local GP. Staff assessed patients' needs for food and drink and for specialist nutrition and hydration using the Malnutrition Universal Screening Tool. Staff monitored patients' weight and body mass index to check their weight. They supported patients to live healthier lives – for example, through healthy eating advice. However, whilst staff had information on the National Early Warning Score staff were not recording their ratings of patients. This tool was developed by the Royal College of Physicians to improve staff's detection and response to patients' deterioration and know when to refer patients to hospital or their GP.

- Staff were proactively trying to help and encourage patients to communicate their needs. Not all patients had verbal communication skills. The provider employed a speech and language therapist to assess patients' needs and additionally a therapy assistant helped support patients and staff. Staff developed communication passports for patients to help know how to best communicate with them. Staff used Makaton signs and symbols with patients as relevant. Staff used the 'Disability Distress Assessment Tool'. This helped staff to assess patients with severe communication difficulties and distress. Staff displayed a picture of the human body for patients to refer to and help communicate where they had any pain or discomfort. Patients had mood bracelets which could wear to help show staff how they were feeling at that time. Staff used 'talking mats', where pictures can be attached and re-arranged as required to assist with communication. Additionally staff were developing pictorial boards to help patients refer to and communicate their needs regarding their feelings and requests.
- Staff used recognised rating scales to assess and record severity and outcomes such as the model of human occupation screening tool.

Skilled staff to deliver care

- The team included or had access to a range of professionals required to meet the needs of patients . This included doctors, nurses, support workers, a clinical psychologist and therapy staff. The hospital had not had an occupational therapist for three months, but the provider had recruited one who was due to start imminently. The provider had employed an activities coordinator, but they were leaving. The manager had identified staff to assist with activities in the interim.
- Staff received an appropriate induction prior to starting work on the wards. Staff files contained induction checklist. However, the provider had not ensured that all checks on agency staff were thorough as four out of eight agency checks (for one nursing agency) did not detail if staff had experience of working with this patient group.
- The percentage of staff that had an appraisal at our visit was 100%.
- The percentage of staff that received regular supervision was 81% at our visit. However, the provider was not ensuring that all staff received supervision as per their standard of six times in 12 months. Two of 37 (5%) staff had not received supervision in the last three months and four staff (10%) only had one supervision in that time. Managers ensured that staff had access to regular team meetings.
- Managers ensured that staff received the necessary specialist training for their roles. For example staff had epilepsy training 30 January 2019.
- Managers dealt with poor staff performance promptly.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings.
- Staff shared information about patients at effective handover meetings within the team (for example, shift to shift).
- Staff had effective working relationships, with other relevant teams for example, care co-ordinators, community mental health teams and commissioners and local authority social services. Staff supported patients to access local community professionals such as GPs, a dentist and chiropodist.

Adherence to the MHA and the MHA Code of Practice

- All patients were detained under the Mental Health Act 1983/2007 when we visited. One hundred percent of staff 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.

Requires improvement

Wards for people with learning disabilities or autism

- The Mental Health Act administrator oversaw the Mental Health Act paperwork and audited this regularly to make sure it met legal requirements, was up to date and stored appropriately. The latest provider's audit of processes and records on 12 September 2018 showed 99% compliance.
- The provider had relevant policies and procedures for staff to follow and these were being updated by the new provider following the merger. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.
- Patients had easy access to easy read information about independent mental health advocacy.
- 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.
- Staff ensured that patients were able to take section 17 community leave and were assessed before.

Good practice in applying the MCA

- There were no patients subject to Deprivation of Liberty Safeguards when we visited.
- Ninety four percent of staff had had training in the Mental Capacity Act.
- Staff had a good understanding of the Mental Capacity Act, in particular the 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 had access to it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff took all practical steps to enable patients to make their own decisions.
- 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.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- The service had arrangements to monitor adherence to the Mental Capacity Act.
- Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it. The latest provider's audit of processes and records on 24 October 2018, showed 99% compliance.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- 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.
- Staff supported patients to understand and manage their care, treatment or condition. Staff were proud of their success at supporting patients to move out of the hospital.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services.
- Patients communicated to us that staff treated them well and behaved appropriately towards them.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.
- Staff maintained the confidentiality of information about patients.

Involvement in care

- Staff oriented patients to the hospital on admission.
- Staff involved patients in their care planning and risk assessments. For example patients knew they had a care plan and what support staff gave them. We found examples of artwork or where patients had personalised and decorated their care plan folders to make them unique for them. Staff had developed with patients 'my day care plans' and a one-page profile detailing patients' strengths and needs to give to new staff with details such as 'how you can help me' and 'what's important'.
- Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

Requires improvement

Wards for people with learning disabilities or autism

- Staff ensured that patients could access a generic advocacy service.
- Staff informed and involved families and carers appropriately and provided them with support when needed.
- Staff enabled families and carers to give feedback on the service they received via care and treatment reviews.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- Information from the provider showed there was a 100% bed occupancy from 30 June 2018 to 30 December 2018. However, there was always a bed available when patients returned from leave. One patient was more than 50km away from family or friends, which could pose difficulty keeping in contact with them and their local community.
- The average length of time from referral to assessment was seven days. The average length of time from assessment to treatment was 52 days. Referrals to the service went to the provider's identified single point of contact for screening before they were sent to the hospital. However, the assessment was not multi-disciplinary as the hospital manager generally visited and assessed the patient alone. Following this the assessing staff member discussed with other team members and a decision was made if they could offer the patient appropriate treatment and care.
- The average length of stay was 782 days from 1 January 2018 to 31 December 2018. This was an increase since our last inspection in June 2017 (408 days) and above the national average (554 days). There were seven delayed discharges during the same time period, which had reduced to five patients when we visited. This could present a risk that the provider was not assertive with other agencies to move patients on, so they spent the least amount of time in hospital. However, staff gave examples of how they were supporting patients to move on to alternative placements. They said that delays were often beyond their control due to an appropriate placement being sought by the community team and funding agreed. We saw examples of staff discharge planning with patients and patients and carers were satisfied with the arrangements for this.
- Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or temporary transfer to another unit.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories.
- Patients could personalise bedrooms. Patients had been involved in choosing the ward's new pink decoration of walls, with some butterflies and flowers. Furnishings were safe and secure but helped create a homely environment.
- Patients had somewhere secure to store their possessions.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care (clinic room to examine patients, activity and therapy rooms).
- Patients could make a phone call in private.
- Patients had access to outside space.
- The provider employed chefs. Patient's we spoke with were satisfied with the food. They had access to hot drinks and snacks. We had received some negative feedback about this before our inspection and the provider investigated this further. They gave examples of how patients had choices about the menu which had been changed to include more sandwiches. There was a menu choice board for patients to identify what they wanted. Staff had received training to provide food for patients when the chef was not on duty.
- Due to the layout of the building some patients said the hospital was noisy at times and there was not much quiet space. This was also given as feedback in the provider's October 2018 patient survey. During hot and cold weather the conservatory was not always used which impacted on space.
- The manager said they had taken action to reduce noise and help patients cope through getting ear defenders for patients; reminding patients to keep their bedroom doors closed when watching television and reminding patients not to shout.

Requires improvement

Wards for people with learning disabilities or autism

Patients' engagement with the wider community

- Patients had individual activity programmes and had access to activities throughout the week including weekends.
- Staff supported patients to maintain skills for independence and living in the community. For example to make themselves drinks, prepare meals, wash their own clothes, or any other task they may need to do in the community (with or without support) when discharged.
- Staff supported patients to maintain contact with their families and carers.

Meeting the needs of all people who use the service

- The service made adjustments for disabled patients – for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs.
- The provider had information and correspondence in formats that patients could read and understand, for example in easy read or large print. The information provided was in a form accessible to the particular patient group for example, the provider had easy read information leaflets, posters and booklets. They had a good range of visual information displayed on walls and doors for patients including activity timetables, Makaton signs, 'now and next boards' and photo cards also as key rings Managers ensured that staff and patients had easy access to interpreters and/or signers. However, the provider had not completed a specific assessment of how they were meeting the accessible information standards to meet patients' needs. There is a requirement of all providers of NHS care and publicly-funded adult social care to follow the Accessible Information Standard in full of 1 August 2016 onwards - in line with section 250 of the Health and Social Care Act 2012.
- Staff ensured that patients could obtain information on treatments, local services, patients' right such as how to complain and what the care programme approach was. Staff displayed a tree picture with photographs of staff, so patients knew who was who.
- Patients had a choice of food to meet the dietary requirements of religious, cultural, spiritual or ethnic groups.
- Staff ensured that patients had access to appropriate spiritual support.
- Staff had identified some patients' protected characteristics in line with The Equality Act 2010, such as age; disability; race; religion or belief and sex but did not detail other protected characteristics for example sexual orientation, which could pose a risk that needs may not be identified and met.

Listening to and learning from concerns and complaints

- Information from the provider from 1 January 2018 to 31 December 2018 showed there was one complaint which was not upheld. The provider had received two complaints since that time relating to staff communication following an incident which was being investigated.
- Patients and carers knew how to complain or raise concerns.
- 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.
- Where relevant, staff received feedback on the outcome of investigation of complaints and acted on the findings.
- Staff displayed 'you said we did' information in their board room (although not dated). For example, the provider had acted to give greater menu choice; improve communication with staff via staff handovers; asked the activity lead to plan more community trips and gained more cutlery. The manager said they got lots of positive feedback but were not always recording the compliments they received.

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

Requires improvement

Leadership

- The provider had not fully ensured that leaders had the skills and knowledge to perform their roles. For example the current manager had requested leadership training and was still waiting for this. They had also requested

investigation training. They had identified gaps in their knowledge relating to safeguarding adults and had been working to address this with the local safeguarding team.
- The manager had a good understanding of the hospital. They could explain clearly how the team worked to provide high quality care.
- The hospital manager and regional manager were visible in the service and approachable for patients and staff.
- Leadership development opportunities were available, the provider had advertised for a deputy hospital manager.

Vision and strategy

- The providers' vision and strategy had changed since our last inspection in 2017. The new provider's senior leadership team had communicated their vision and values to the frontline staff in this service. They had sent information to staff about the changes and offered opportunities for staff to attend meetings to learn about them. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.
- The provider had identified the following values 'integrity, trust, empower, respect and care'. Staff were able to talk about these in their work.

Culture

- Staff we spoke with felt respected, supported and valued. They felt positive and proud about working for the provider and their team. Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process. Managers dealt with poor staff performance when needed. However in response to recent staff concerns and some feedback from the provider's staff survey, the provider was developing clinics by their human resource team. These would give staff opportunities to discuss any concerns they may have. The provider was also planning a '360-degree feedback' consultation with staff with opportunities for them to identify any strengths or areas for improvement on management behaviours or competencies.
- We asked the provider how the hospital was meeting workforce race equality standards with staff. The provider did not give us information about their analysis of data for this and feedback from their staff survey. However, they stated they had 41% of black or ethnic minority staff in different roles and positions and would continue with positive recruitment practices. The provider stated they would concentrate on encouraging staff and new starters to complete details about their ethnicity, so more complete statistics could be reported. The provider gave staff equality and diversity training as a part of their induction and a on an e-learning package and when we inspected 100% staff had completed this.The provider stated they gave feedback to staff after the staff survey via the 'you said' we did board'.
- The service's staff sickness and absence were similar to the provider's target.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. The provider gave staff questionnaires on leaving to capture any feedback or themes, but staff did not always complete these.
- The provider recognised staff success within the service – for example, through staff 'shining star' awards.

Governance

- The provider had a clear framework of what must be discussed at a ward, team or directorate level in hospital staff meetings, unit led clinical governance meetings, to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However, the provider did not give assurance of how they monitored and assessed the use of staff restraint with patients across the hospital and taking action to reduce them. For example, governance meeting minutes showed reviews of incident trends but not a review of restraint data although this was an agenda item for 'actions to reduce the use of restrictive physical interventions'.
- Staff had implemented recommendations from reviews of incidents, complaints.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. Staff undertook or participated in local clinical audits. The provider had a 'Quarterly Development Review audit' which benchmarked the hospital against the five CQC domains. In April 2018 there was 81% compliance at this location.

Requires improvement

Wards for people with learning disabilities or autism

Management of risk, issues and performance

- The provider had not ensured there was sufficient oversight and understanding of safeguarding vulnerable adults' processes which was not clearly identified on their risk register. However, staff had identified risks for staffing and the environment. The provider had identified improvements were needed for recruitment. The provider stated after the inspection that subsequent training has been implemented and provided around safeguarding education for staff.
- The service had plans for emergencies – for example, adverse weather or a flu outbreak.
- The doctor and psychologist held a quality assurance 'walk around' to offer staff the chance to raise any concerns or issues they needed assistance with.

Information management

- Staff had access to the equipment and information technology needed to do their work.
- Information governance systems included confidentiality of patient records.
- Team managers had access to some information to support them with their management role. This included information on the performance of the service, staffing and patient care. However, one staff personnel file did not have information about an investigation which was held at provider level.
- Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Engagement

- Staff had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins and newsletters.
- Patients had opportunities to give feedback on the service they received in a manner that reflected their individual needs. For example patients could give feedback via an annual patient survey. Patients were involved in decision-making about changes to the service and the 'Patient empowerment meeting' and a 'Regional Patient Forum'. The provider did not hold carers meetings.
- Managers and staff had access to the feedback from patients, and staff and used it to make improvements. Staff gave feedback via the provider's annual survey although the manager said the response rate was low and they were trying to improve this.
- Patients and staff could meet with members of the provider's senior leadership team to give feedback.

Learning, continuous improvement and innovation

- The provider had a quality assurance system to consider opportunities for improvements and innovation and this had led to changes. For example staff had made improvements to their incident debrief process.
- The location currently did not participate in accreditation schemes relevant to the service.

Outstanding practice and areas for improvement

Outstanding practice

Staff were creative and had developed a variety of ways to help patients to non-verbally communicate their needs and choices and express how they were feeling. This had empowered patients to be more self-reliant. For example, staff had displayed a picture of the human body for patients to point at to let staff know where they had any pain or discomfort. Patients had different coloured 'mood' bracelets they could wear to help show staff how they were feeling at that time. Staff displayed visual information on walls and doors such as activity timetables, Makaton signs, 'now and next boards' and had photograph cards also on key rings to help patients know what was happening that day and let staff know what they wanted. Staff also used 'talking mats' to communicate with patients for example when completing the annual patients survey, where pictures could be attached and re-arranged as required. Staff used a pictorial easy read debrief form with patients following restraint incidents to capture patients' experience and feedback to help reduce reoccurrence.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure sufficient checks of agency staff take place to ensure they are safe to work with patients.
- The provider must ensure staff have clear information (such as protection plans) detailing care and treatment they should give to safeguarding patients following safeguarding incidents.
- The provider must review their safeguarding policy to ensure it reflects agency staff checks, staff training required, and protection plans.
- The provider must ensure staff always accurately record their observation checks of patients.
- The provider must review their governance systems to ensure sufficient assessment, management and mitigation of risks for the hospital.

Action the provider SHOULD take to improve

- The provider should ensure leaders have adequate training and development for their role.
- The provider should ensure there is sufficient gender mix of staff available to meet patient's needs.
- The provider should review their staff recruitment and retention processes.
- The provider should review their governance processes to give assurance of their monitoring and assessment of staff's restraint with patients and take action to reduce them.
- The provider should ensure staff regularly get supervision as per their standard.
- The provider should review their processes for planning patients' discharge from the service.
- The provider should evidence how they are meeting the accessible information standards- in line with section 250 of the Health and Social Care Act 2012.
- The provider should ensure that the hospital comply with reporting requirements for the Workforce Race Equality Standard.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • The provider's governance systems did not give sufficient assessment, management and mitigation of risks for the hospital. • The provider had not ensured staff always recorded their observation checks of patients. • The provider had not ensured sufficient checks of agency staff had taken place to ensure they were safe to work with patients. • The provider had not ensured staff had clear information (such as protection plans) detailing care and treatment they should give to safeguarding patients following safeguarding incidents. • The provider had not ensured their safeguarding policy reflected agency staff checks, staff training required, and protection plans. This was a breach of regulation 12(1)(2)(a)(b)(c)