Requires improvement

Leeds and York Partnership NHS Foundation Trust

# Wards for people with learning disabilities or autism

## Quality Report

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## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| RGD17 | St Mary's Hospital | 2, Woodland Square<br>3, Woodland Square | LS12 3QE |
| RGDPL | Parkside Lodge | Parkside Lodge | LS12 2HE |

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Leeds and York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership NHS Foundation Trust.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

| | |
|---|---|
| Overall rating for the service | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Requires improvement |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Requires improvement |

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated wards for people with learning disabilities or autism as requires improvement because:

- We had a number of concerns about staff on the wards being suitably trained and supervised. Compliance with mandatory training was 75% or below in seven areas, including essential training for the service which is designed to reduce risk to patients: clinical risk assessment (54% at Parkside Lodge), Mental Capacity Act and Deprivation of Liberty Safeguards (75% at 2 Woodland Square), Mental Health Act Awareness (63% at Parkside Lodge), Mental Health Act Inpatients (67% at 3 Woodland Square and 70% at Parkside Lodge) high level personal safety training 68% Parkside Lodge), infection control (71% at 3 Woodland Square) and food safety (71% at Parkside Lodge and 68% at 3 Woodland Square. Staff did not receive supervision every four weeks in line with trust policy and not all staff had an annual appraisal.
- The environment was not safe at 2 and 3 Woodland Square. The wards were not clean and repairs had not been completed when staff had reported them. This increased risk of infection to patients who were vulnerable due to long-term health conditions. 2 Woodland Square did not meet guidance regarding same sex accommodation because male and female patients shared one bedroom corridor and a communal bathroom and there was no female only lounge. However, the service mitigated this risk because most patients were not ambulatory and those who were, staff supported at all times moving through the ward.
- Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged.
- Governance structures did not always ensure the wards ran safely. Staff did not undertake audits of medication and equipment consistently. The inspection team found medication errors, which the service was not aware of. The service did not comply fully with guidance from the Department of Health, Mental Capacity Act and Mental Health Act. This placed patients at risk of staff not upholding their rights. 2 Woodland Square did not use performance indicators to ensure the service was high quality. Staff did not support patients to complain using easy read formats. Clear legal authority had not been obtained to care for patients who lacked capacity to consent to their care and treatment and were deprived of their liberty.
- Staff had not consistently updated care and treatment records at 2 Woodland Square. Care plans, patient evacuation plans and risk assessments contained out of date information and best practice guidance. This placed patients at risk of receiving care, which could cause them harm. 2 and 3 Woodland Square did not always complete service specific risk assessments and care plans.

However:

- We witnessed compassionate care and saw good practice such as communication profiles to assist staff to ensure sharing of patient views. The feedback from patients and carers was wholly positive about the way staff talked with, and treated them. Patients were involved in their care and staff encouraged patients to talk about their needs.
- There were no waiting lists and the service offered emergency placements to patients when carers needed support. The service had an ethos of multidisciplinary working and the recording of incidents was good. Service level lessons learned were being shared and de-briefs took place after all incidents, which included the patient. At Parkside Lodge, professionals were working on outcome measures to improve patient recovery.
- The ward managers were innovative and looking at ways to improve the service.
- Staff morale was good and staff told us that they felt supported.

# Summary of findings

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

**Are services safe?**

Requires improvement 

We rated safe as requires improvement because:

- Ward environments at 2 and 3 Woodland Square were not clean. We saw mould in the shower and a dirty shower curtain at 3 Woodland Square. Staff stored mattresses (still packaged), their coats and lockers in the patient shower room at 2 Woodland Square. The sky light at 2 Woodland Square leaked in to the patient lounge when it rained. The risk of infection is higher when areas are not clean and well maintained.
- 2 Woodland Square was not compliant with same sex accommodation guidance as stated in the Mental Health Act Code of Practice. Male and female patients shared the same bedroom corridor and communal bathroom. However, staff reduced this risk by maintaining dignity and respect when mixed sex patients were on the ward. For example, by assisting patients to change in the bathroom, and not moving through corridors in nightwear.
- Staff did not consistently record the temperature of the clinic rooms, where they stored medication and carried out examinations and procedures. This meant that there was a risk to patients of receiving medication that could be harmful or ineffective because it had not been stored correctly.
- We found six medication errors at 2 Woodland Square and Parkside Lodge, which staff had not picked up in audits within the service, which the trust told us, were taking place. The errors happened when nurses had given medication to patients and not signed that it had been administered. This meant that there was a risk nurses gave medication to patients twice. However, staff told us that audits were not taking place, as outlined in the trust policy.
- Compliance with mandatory training was 75% or below in seven areas , including essential training for the service designed to reduce risk to patients, such as: clinical risk assessment (54% at Parkside Lodge), Mental Capacity Act and Deprivation of Liberty Safeguards (75% at 2 Woodland Square), Mental Health Act Awareness (63% at Parkside Lodge), Mental Health Act Inpatients (67% at 3 Woodland Square and 70% at Parkside Lodge) high level personal safety training 68% Parkside Lodge), infection control (71% at 3 Woodland Square) and food safety (71% at Parkside Lodge and 68% at 3 Woodland Square.

# Summary of findings

- Staff had not updated patient evacuation plans since 2013 on 2 Woodland Square. This put patients at risk because staff would not be following the correct information in an emergency.
- The seclusion facility at Parkside Lodge did not meet with the requirements in the Mental Health Act Code of Practice despite the room having a recent redesign. The door to the room was not wide enough to move a patient safely in restraint this meant that injury could be caused to staff and patients. There was no two-way communication facility so that patients could speak with staff and no access to natural light or fresh air.

However:

- Seclusion records were thorough, and nurses and doctors carried out reviews in a timely way.
- Safeguarding practice was good and we saw evidence of staff making timely referrals.
- There was evidence that staff reported of incidents, and reviewed and learned lessons from incidents and involved patients.
- Staff had a good understanding of the duty of candour and were able to give examples of how they used this.

**Are services effective?**

**Requires improvement**

We rated effective as requires improvement because:

- Parkside Lodge practices were not in line with Mental Health Act Code of Practice. There was no notice for informal patients telling them how they could leave the ward. This meant that patients might not understand their right to leave. Staff at Parkside Lodge did not always complete consent to treatment after three months of treatment for patients who lacked capacity to make decisions about their care and treatment or medication.
- Compliance with mandatory training was 75% for the Mental Capacity Act and Deprivation of Liberty Safeguards at 2 Woodland Square, and we had concerns about staff practice in these areas.
- Patients at 2 and 3 Woodland Square lacked capacity to consent to their respite care and treatment. They were subject to continuous supervision and control and not able to leave. Patients were also cared for using some methods of restraint such as high padded bedsides to prevent them falling from their bed and wheelchair harnesses and straps. The service had

# Summary of findings

carried out capacity assessments but had not made applications for Deprivation of Liberty Safeguards. These safeguards are a lawful requirement to ensure the service upholds the human rights of patients.

- Ten out of the 12 care plans that we reviewed at 2 Woodlands square were beyond the review date and contained incorrect information about the administration of important medication such as drugs used as a rescue medication for patients with severe epilepsy. Care plans contained out of date guidance about procedures such as gastrostomy care. We reviewed care plans of patients currently staying on the ward, and care plans of patients who are regular users of the service.
- Staff did not receive regular supervision. Only 46% of staff had received clinical supervision at Parkside Lodge and 35% at 3 Woodland Square. Management supervision rates were higher at 70% and 73%. The service had not given staff opportunity to discuss how to improve their performance and identify training and development needs. This increased risk to patients because there was reduced opportunity for staff to learn and improve practice.
- The service did not ensure that it gave staff annual appraisals as per trust policy. At 3 Woodland Square 64% of staff had received an annual appraisal and only 55% at Parkside Lodge). Staff who the service did not give regular updates to about the trust's values and vision increased risk to patients, as the service had not made them aware of changes required in their practices and their performance was not being assessed.

However:

- Assessments were holistic and person centred, and staff completed detailed communication profiles to encourage participation.
- Staff invited advocacy services and independent mental health/ mental capacity advocates to multidisciplinary meetings at Parkside Lodge.
- Multidisciplinary team working was evident throughout all of the services we visited and we found that staff referred to their colleagues in the community for support when required.

**Are services caring?**

Good

We rated caring as good because:

- Staff spoke to patients with dignity, respect and at an appropriate level.
- Patients said they felt safe on the wards and that staff were easy to talk to.

# Summary of findings

- Carers were positive about the way staff treated patients.
- We witnessed compassionate care at all sites and good examples of practice such as communication profiles, to ensure staff took patients' needs and wishes into account.
- Staff at Parkside Lodge asked patients to feed into their multidisciplinary meetings in a patient, learning disability accessible manner, to ensure staff heard their views, and they could monitor their progress.
- Staff supported patients to make choices and decisions about their care and treatment.

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

**Good**

We rated responsive as good because;

- There were no waiting lists at any of the locations. When the service had capacity for more patients, they offered additional stays to patients and carers who were vulnerable or at risk.
- The respite services offered emergency provision to carers, for example if a carer became ill, the service was flexible to offer respite stays to patients to allow their carer to recover.

However:

- 2 Woodland Square was not compliant with same sex accommodation guidance as stated in the Mental Health Act Code of Practice. Male and female patients shared the same bedroom corridor and communal bathroom. However, staff reduced the risk of loss of dignity by; assisting patients to change in the bathroom, and not moving through corridors in nightwear. Risk was also reduced because patients were not independently ambulant and supervised by staff at all times when moving through the building.
- Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged.
- There were no easy read format complaints leaflets to assist patients with learning disabilities to make complaints.

**Are services well-led?**

**Requires improvement**

We rated well led as requires improvement because;

# Summary of findings

- A number of issues across the service related to a lack of governance structures on the wards.
- Governance structures did not ensure that staff had undertaken appropriate levels of mandatory training and supervision and appraisal.
- Key performance indicators were not being used at 2 Woodland Square to measure the performance of the service.
- Audits of medication, equipment and infection control were not taking place as stated in the trust policy, and we saw that errors were being missed which managers were unaware of, such as medication mistakes.

However:

- Managers were innovative and looking at ideas for service development.
- The use of multidisciplinary team working was good and supported patients' recovery because staff worked together to ensure the best outcome for the patient.

# Summary of findings

## Information about the service

Leeds and York Partnership NHS Foundation Trust provide inpatient services on wards for adults with learning disabilities or autism at three locations:

**2 Woodland Square**

This service provides planned care (respite) for male and female adults with complex and multiple impairments. The service has five beds. Three patients were using the service at the time of our inspection.

**3 Woodland Square**

This service has a dual purpose, providing care for both males and females. One side of the building has four beds for planned care (respite) for adults with learning disabilities and challenging behaviour. The other half has four beds and is a recovery and rehabilitation service for adults with learning disabilities. Three patients were using the respite service at the time of our inspection. There were no patients using the recovery and rehabilitation service for adults with learning disabilities at the time of the inspection.

**Parkside Lodge**

This service is an acute inpatient assessment and treatment ward for male and female adults with learning disabilities. The service has 11 beds, and had six patients admitted at the time of our inspection.

We visited these services on 12, 13 and 14 July 2016. We visited 2 Woodland Square for a second time on 20 July 2016 in the evening.

An unannounced focused inspection took place at Parkside Lodge in April 2016, because of concerns raised about the service regarding seclusion facilities, staffing numbers and how the service used the Mental Health Act with patients who were detained. We found the following issues of concern during this inspection:

- The trust had not ensured that staff were up to date with the Mental Health Act and Mental Capacity Act training.
- The trust had not ensured that all ligature risks were identified and added to the local risk register, and ensured that the ligature risks were mitigated by the removal of those risks where possible.

We last inspected all the services in October 2014 as part of the trust announced comprehensive inspection, and rated the core service of wards for people with learning disabilities or autism as good overall. There were no breaches of regulation. However, there were issues in relation to supervision and training compliance at 3 Woodlands Square and Parkside Lodge.

Care Quality Commission Mental Health Act reviewers last visited Parkside Lodge in May 2015. They found that:

- the ward did not have a quiet area, relaxation or sensory room
- section 132 forms were not fully completed to evidence that patients had been made aware of their rights under the Mental Health Act (1983)
- approved Mental Health Act professionals' reports were not available with patients' paperwork
- risk assessments were not reviewed after a significant change
- not all leave forms were completed correctly
- the seclusion room was not compliant with the Mental Health Act Code of Practice (2015)
- medical reviews of patients in seclusion were not always timely.

## Our inspection team

The team responsible for inspecting Leeds and York Partnership NHS Foundation Trust was led by:

Chair: Phil Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

# Summary of findings

Head of Hospital Inspection: Nicholas Smith, Head of Hospital Inspection (North West), Care Quality Commission

Team leaders: Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission

Chris Watson, Inspection Manager, Care Quality Commission

The team inspecting wards for people with learning disabilities or autism comprised a Care Quality Commission inspector and five specialist advisers, including a mental health act reviewer, a mental health specialist nurse, a mental health specialist social worker, a psychologist and an occupational therapist. An expert by experience also joined the inspection at 2 Woodlands Square; this person had personal experience of supporting family members who are adults with autism.

## Why we carried out this inspection

We inspected this core service as part of our on-going 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 service, asked a range of other organisations for information and sought feedback from patients, carers, staff and allied health professionals at three focus groups.

During the inspection visit, the inspection team:

- spoke with nine patients, and collected feedback from nine patients using comment cards
- spoke with 18 carers of patients using the service
- visited all three wards and looked at the quality of the environment
- spoke with the modern matron responsible for these wards
- spoke with the psychiatrist with responsibility for one of the services
- spoke with the psychologist with responsibility for one of the services
- spoke with the visiting GP
- spoke with the ward managers of all three wards
- spoke with 13 staff and attended staff focus groups
- attended a handover meeting on each ward
- attended an multidisciplinary meeting
- visited a ward in the evening
- observed interactions between staff and patients.
- reviewed the Mental Health Act paperwork of six patients at Parkside Lodge
- reviewed 30 prescription charts, and undertook a specific check of medication storage and practice on each ward
- looked at 27 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

# Summary of findings

We spoke with nine patients during our inspection. All patients spoke positively about the service. They told us that they felt safe and could talk to staff about their worries and feelings. Patients said that food was good, and the patients from Parkside Lodge talked about how much they were able to go out with staff support and that they enjoyed this. One patient was able to tell us about their care plan and had a good understanding of this.

One patient at 2 Woodland Square told us that bedtimes were too early; the carer of a second patient also said this.

Patients felt able to speak to the doctors and have visitors whenever they chose.

We spoke with 18 carers of patients using the service. Carers gave wholly positive feedback about the staff, telling us that they were kind, caring and compassionate and that they felt their relative was safe in their care. Carers said that discharge was excellent and that their relative always came home from respite with a detailed description of how their week had been. Carers of patients at Parkside Lodge told us that staff invited them to meetings and involved them in decision-making.

We received negative feedback from six of the 18 carers that there were no activities in place at 2 Woodlands Square because transport was not available. They told us that their relative was not able to go out at weekends due to this, when they live an active lifestyle at home. Carers found this disappointing.

## Good practice

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that all patients who lack capacity to consent to their care and treatment are cared for using the appropriate legal authority such as by Deprivation of Liberty safeguards.
- The provider must ensure that staff complete mandatory training, and that the service offers appraisal and supervision regularly and in line with trust policy.
- The provider must ensure that staff update patient care plans and evacuation plans at 2 Woodland Square and that they contain relevant guidance and link with risk assessments.

### Action the provider SHOULD take to improve

- The provider should ensure that infection control practices improve that the trust repairs risks identified by staff in a timely manner at 2 and 3 Woodland Square. Including the removal of mattresses and staff belongings from the patient shower room and the sky light repair.
- The provider should ensure that staff monitor and record the temperatures of clinic rooms.
- The provider should ensure staff carry out thorough medication and equipment audits to reduce risk of errors occurring or going undetected, in line with trust policy.
- The provider should ensure that patients at 2, Woodlands Square are cared for with dignity and respect, due to the sharing of same sex accommodation and communal bathrooms.
- The provider should ensure that it adheres to guidance in the Mental Health Act (Code of Practice) at Parkside Lodge.
- The provider should ensure that patients at 2 Woodland Square can access activities and that the staff and the people who use the services are aware that appropriately adapted transport can be facilitated where required.
- The provider should ensure that information is available in accessible formats to assist patients to make complaints.
- The provider should ensure that 2 Woodland Square have performance indicators which are measurable to ensure the quality of the service can be reviewed and monitored.

Leeds and York Partnership NHS Foundation Trust

# Wards for people with learning disabilities or autism

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| 2, Woodland Square<br>3, Woodland Square | St Mary's Hospital |
| Parkside Lodge | Parkside Lodge |

## 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.

There were no patients detained under Mental Health Act at 2 and 3 Woodland Square. There were six patients detained under the Act at Parkside Lodge during the inspection.

Staff filed section 17 leave forms appropriately and put a line through old forms. Staff discussed section 17 leave arrangements at multidisciplinary team meetings. Patients told us that staff never cancelled their leave and they used this appropriately.

Training in awareness of the Act was at 83% at 2 Woodland Square and 63% at Parkside Lodge which is below the trust target of 90% in all services. This put patients at risk, particularly at Parkside Lodge, of staff being unable to uphold their rights and provide information and advice.

We reviewed the files of six detained patients at Parkside Lodge, and found that hospital manager hearings and tribunals were taking place, as they should. For patients who lacked capacity staff automatically called a tribunal. Staff read patients their rights under section 132 of the Mental Health Act at the correct time and used easy read versions with patients who had learning disabilities. None of the files contained the Approved Mental Health Professionals' report. The Mental Health Act Review visit in 2015 raised this issue, and practice has not changed since this time.

Patients had good access to Independent Mental Health Advocates and Independent Mental Capacity Advocates at Parkside Lodge.

Staff were able to contact the psychiatrist for support and advice regarding the Act and would contact the Mental Health Act office within the trust.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

Completion of mandatory training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) was below the trust target of 90% at 2 Woodland Square (75%) and Parkside Lodge (81%).

Despite the lower levels of training at Parkside Lodge, staff were knowledgeable about the Act and we saw evidence of them carrying out capacity assessments when patients needed to make specific decisions. Best interests meetings were taking place at multidisciplinary team meetings which staff invited families and Independent Mental Capacity Advocates to in order to support the patient.

Practice in relation to the Mental Capacity Act was a concern at 2 Woodlands Square. Staff had undertaken mental capacity assessments with 22 of the 24 patients accessing the service. Seven of those assessments stated that patients lacked capacity to consent to respite stays and to their care and treatment. Clear legal authority had not been obtained to care for patients who lacked capacity to consent to their care and treatment and were deprived of their liberty.

Requires improvement

# Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Our findings

### Safe and clean environment

**2 Woodland Square**

The design of 2 Woodland Square did not meet the needs of the patient group. Boxes of medical equipment such as continence products and wipes were stored in patient bedrooms and on corridors. The ward only had one storage room, which also meant that patients were unable to bring all of their specialist equipment when they stayed.

The ward was not safe because infection control practices were poor. Staff kept coats and lockers in the communal patient bathroom. We found three mattresses stored in the bathroom, (although these were packaged in plastic) Staff told us that this was because the building did not have enough storage space. When things are not stored correctly, it increases the chance of the spread of infection. This risk was high for this patient group due to their complex health needs. The trust completed an infection control audit in May 2016 and there were outstanding issues from this audit on our visit. Staff told us that they completed a deep clean of every bedroom after each patient left, however cleaning records were not available to confirm this.

There were ligature points and blind spots (areas were staff could not see patients) throughout the ward. A ligature point is something that people can use to tie something to in order to be able to strangle themselves. Staff were aware of these because they had assessed them and included them on the service risk register. The service reduced these risks because patients were not able to walk unaided; staff observed those patients who were mobile throughout the day and night.

The ward did not comply with same sex accommodation guidelines written by the Department of Health (2010) and within the Mental Health Act Code of Practice. Male and female bedrooms were on the same corridor, there was a mixed sex communal bathroom and the service did not have a female only lounge. The Mental Health Act Code of Practice (paragraphs 8.25-6) states that:

"All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms."

However, there were exceptional circumstances for this ward, due to the need for patients to have specialist bathroom equipment, which the service could only provide in the communal bathroom. Staff maintained patients' dignity and privacy because they did not pass members of the opposite sex not fully clothed. The issue was because the facilities and space available on the ward, and its layout did not meet the needs of the patients.

The clinic room was fully equipped, and resuscitation equipment was available. Nurses checked the defibrillator daily. There was a well-stocked grab bag, and equipment such as the blood pressure machine, suction machine and pulse monitor were all working and tested. However, on 13 and 20 July 2016 the clinic room door was wedged open, despite notices reminding staff to close the door. The risk was low because the two patients using the service at the time were unable to access the room independently.

The ward had a clinic room; this was tidy but cluttered due to items being stored in the room. The clinic room did not have an examination couch, meaning that staff did any examinations in patient bedrooms. This may increase risk to the patient group due to the increased risk of infections when medical procedures are carried out in a non-clinical area. The service did not monitor the clinic room temperature.

Woodland Square received a score of 99% in the 'patient led assessment of the care environment' survey in 2015. This process is where local people go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not coverclinical care or how well staff do their job. This score was 1.4 % above the average for England.

2 Woodland Square did not have nurse call points in place for nurses or patients to use in an emergency. Staff told us that they did not think they were required because the patient group was unlikely to present challenging

behaviour. Staff would need to call for assistance for reasons other than challenging behaviour. For example, without call systems, nurses had no ability to call for help in a medical emergency such as a prolonged seizure.

**3 Woodland Square**

3 Woodland Square was split into two areas. One side of the ward was a respite service and the other a rehabilitation and recovery service. Both areas had four beds. During our visit, there were no patients using the rehabilitation and recovery service and it had been unused for 18 months. This side of the ward had a seclusion room, which was no longer in use. Although the rehabilitation service was not in use, we inspected it because the manager told us that the service could be used in the event of an emergency.

It was not possible to observe patients at all times at 3 Woodland Square, due to the layout of the ward. Staff observed patients when moving around the ward, and being present in communal areas mitigated the risk. There were ligature points throughout the ward such as the taps in the bathroom and the blinds situated at the end of the corridors. Staff were aware of these because they had been included on the service risk register.

The ward was not safe because infection control practices were poor. There was mould on the base of the shower in the communal bathroom and the shower curtain was dirty. The bathroom light did not have a long enough pull string, and staff had tied a plastic balloon rod to it. The manager had reported these problems to the estates department but the service had not dealt with them. The staff replaced the shower curtain during our visit. We saw that decoration throughout both sides of the ward was tired, as was the furniture.

The ward complied with same sex accommodation guidelines because male and female patients did not use the service at the same time. The service had male and female only weeks for respite. Male and female patients would have to share the same corridor and use the same communal bathroom if staff planned their stays together.

3 Woodland Square had a clinic room, which was clean and tidy. Labels were on all equipment to show staff had recently cleaned it. There was an examination couch available in the room. The grab bag was in place and all items were present. Staff kept a ligature knife in a locked cupboard with the medication stock and the qualified nurse on shift held the key. This meant that it would not be quickly available in an emergency. We saw that equipment such as the blood pressure machine and pulse monitor were working and tested. The medication fridge was clean and locked although a cleaning schedule for the fridge was not in place. Staff did not monitor the temperature of the clinic room.

**Parkside Lodge**

There were blind spots and ligature points throughout the ward and in patient bedrooms. Staff had assessed these and included them on the service risk register. Staff mitigated risks to patients by observing them throughout the day and night. Observation levels changed if a patient was at risk of using ligatures. Staff told us that there had not been an incident for a number of years. However, we found that some areas of the ward were isolated from line of sight of staff and contained significant ligature risks such as window closers. Staff were aware of these areas and told us that there observation policy included these areas. There were ligature points in the communal bathrooms, which staff locked when not in use. We were concerned that there were ligature risks in both communal bathrooms and no viewing point for staff. This meant that staff would need to remain in the bathroom while patients were using it, or that staff would need to keep the door open. This presented an issue with privacy and dignity for patients. The trust continued to work on plans to remove all ligature points from the ward, and showed us their schedule of works.

Staff monitored the clinic room temperature and it was clean and tidy. An examination couch was available in the doctors' room. The grab bag was present and all equipment correct. There was a ligature rescue knife available and the service kept this in the controlled drugs cupboard. The keys to this cupboard were kept by qualified nurse in charge, meaning that this was not readily available in the event of an emergency. The service kept all medication including controlled drugs in a locked cupboard. There were notices in the clinic room regarding how to respond in an emergency.

Some areas of the ward were not clean. In the female communal bathroom, the flooring was stained and the shower hose was dirty. In bedroom three on the male corridor, the window frame on the door was broken and staff had held it together with medical tape.

Requires improvement

# Are services safe?

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

The ward had a male and female corridor and a female only lounge so complied with same sex accommodation guidance from the Department of Health and in the Mental Health Act Code of Practice.

Parkside Lodge had a seclusion room, which the trust had re-designed following concerns raised at our previous visits. The room did not meet all seclusion guidance from the Mental Health Act Code of Practice. The door was not wide enough to bring a patient safely into the room in restraint holds, which increased the risk of injury to staff and patients. The room had a communication system, but this was not two-way. Staff could speak to patients through the system, but patients could not use the intercom to reply. The room had no natural light and no access to fresh air. There was a clock and an ensuite bathroom with a shower, which did not contain any ligature points. The line of sight into the room was good.

Parkside Lodge had a de-escalation room, which patients could use as a less restrictive environment than seclusion when they needed to spend time away from the ward. Staff restrained patients in this room. However, staff told us that this was for the least amount of time possible, and we saw records that staff moved quickly down a scale of restraint when using this room. For example, by repeatedly letting go of arm holds to determine if a patient had settled. The room was sparse and was not a therapeutic environment for patients, as it did not contain activities or relaxation equipment. Staff told us that this was because patients could use the equipment for self-harm, but this was not individually risk assessed for patients. The only item in the room was a plastic couch, and it looked like a second seclusion room. The room had a lock on the door, which the service had requested, be removed. Staff told us that they never locked the door. There was a glass panel in the door and the room was in the middle of the corridor between the male and female bedrooms, this did not promote privacy and dignity. Staff told us that they directed patients away from the room when it was in use. We were concerned that the way staff used this room could amount to seclusion, which the service had not recognised.

In 2015, Parkside Lodge received a score of 98% for the patient led assessment of the care environment survey. This was 0.4% above the England national average.

### Safe staffing

A shared whole time equivalent Clinical Team Manager managed Parkside Lodge and 3 Woodland Square.

There were specific staffing complements for the two units, all posts are whole time equivalent figures as follows :

**Parkside Lodge**

Clinical Lead Nurse (Band 6) x 3

Staff Nurse (Band 5) x 8.6

Senior Support Worker (Band 4) x 2

Support Worker (Band 3) x 12.6

**3 Woodland Square**

Clinical Lead Nurse (Band 6) x 2

Staff Nurse (Band 5) x 6.2

Senior Support Worker (Band 4) x1

Support Worker (Band 3) x 11.9

A following multidisciplinary team worked across both wards, although spent most time at Parkside Lodge. The team comprised of:

Consultant Psychiatrist x 0.8 whole time equivalent

Junior Doctor x 1

Consultant Psychologist x 0.5 whole time equivalent

Occupational Therapist (Band 6) x 1

Dietician x 0.4 whole time equivalent

Admin Staff x 2

**2 Woodlands Square**

Clinical Team Manager (Band 7) x1

Clinical Lead Nurse (Band 6) x2

Staff Nurse (Band 5) x5.2

Support Worker (Band 3) x 6.2

Due to the respite nature of the services at both 2 and 3 Woodlands Square, the majority of input from the multidisciplinary team such as, psychiatry, dieticians, speech and language therapy, and physiotherapy came from the community learning disability services on an individualised basis. This maintained the continuity of care that they provided in the community for the patient.

The ward manager was not included the staffing numbers. However, the manager from 2 Woodland Square told us that they spent 80% of time as part of the nursing numbers

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

on the ward due to low staffing, and only 20% of their time on management responsibilities. The impact of this was that the manager was unable to complete audits and undertake management responsibilities.

The trust provided data in relation to staffing turnover and sickness from 1 January 2016 to 1 June 2016. The average vacancy rate across the trust was 14%. Two Woodland Square had a vacancy rate for whole time equivalent qualified nurses of 0.3 and nursing assistants of 0.5 (0.8 in total). Parkside Lodge had no vacancies for nursing assistants and 1.7 whole time equivalent vacant qualified nursing posts; this meant that both wards were below the trust average vacancy rate. The manager at Parkside Lodge explained that there had been a recruitment drive and the trust had employed 14 new staff. This was a significant improvement from April 2016 when there were five qualified nursing vacancies on this ward.

3 Woodland Square had the highest vacancy rate of 2.5 whole time equivalent vacancies for qualified nurses and 4.1 for nursing assistants; at 23%, this was higher than the trust average. The staff turnover was also high on this ward as two staff members had retired in the last twelve months.

The trust had an average sickness rate of 5% Parkside Lodge exceeded this target at 5.3% as did 2 Woodland Square at 7%. Sickness rates were lower at 3 Woodland Square (3.3%). The manager at 2 Woodland Square explained that sickness levels were higher on this ward due to long-term sickness of one staff member.

The use of bank and agency staff varied between wards. Low rates of bank and agency usage are preferable because it means that patients see regular staff delivering their care, and staff who have in depth knowledge of the processes and systems used on the ward.

At 2 Woodland Square, bank staff filled 86 shifts. The manager told us that these were staff already employed by the ward, i.e. permanent staff working extra shifts. The manager explained that the ward did not use agency staff due to the complex skills required to undertake work with the patient group. At 3 Woodland Square, bank or agency staff filled 98 shifts. The managers filled all but one shift on these wards.

Bank and agency staff use was high at Parkside Lodge with 969 shifts filled by bank or agency staff. The manager explained that this was because they had increased staffing numbers to two nurses on night shifts. Therefore, the ward used one bank staff each night. Between January and June 2016, the manager had been unable to fill 94 shifts at Parkside Lodge. The manager explained that this had improved following recruitment. The manager also explained that when they could not fill shifts, the ward did not admit new patients to ensure the service provided safe care. We saw evidence of this in the low bed occupancy at Parkside Lodge. Shifts not being filled puts patients at risk because the staff could not support them adequately.

Ward managers told us that they were able to adjust staffing levels by calling in bank or agency staff, dependent on the changing needs on the ward and did not have concerns about doing so.

During our visits to all three wards we saw that there were qualified staff in communal areas of the wards at all times observing patients.

We saw no evidence of avoidable cancellation of section 17 leave, outings or appointments, and patients, carers and staff raised no concern over this. Staff only cancelled activities if an emergency occurred, or if it was not safe for the patient to leave the ward. Staff re-arranged any cancelled activities within 24 hours.

The staffing ratios and numbers varied between wards;

**2 and 3 Woodland Square**

The minimum staffing levels on the wards were one nurse and one healthcare assistant working on the early shift (7:30am to 3:30pm) and late shift (12:00pm to 8:00pm). The night shift was the same staffing level. Staffing levels were flexible dependent on patient need and changes on the ward. Because these were respite wards, the service planned patient stays for the coming year. The majority of the time, unless there was an emergency, the manager changed staffing levels according to the needs of the patient group on the wards. 3 Woodland Square and Parkside Lodge shared staffing if patient needs changed.

Staff had considered the patient mix, for example, they would not admit patients who needed two to one staffing with other patients with high-level needs.

We were concerned that staffing levels at 2 Woodland Square did not take into account what would happen in a clinical emergency, for example if a patient became unwell and needed to go to hospital, because only two staff worked on the ward at one time. However the trust told us that they relied on their out of hours management and

support arrangements to effectively manage a clinical emergency. This included calling staff from 3 Woodland Square. The trust told us that there had been a number of occasions where they had to redeploy staff across services in an emergency (including unexpected sickness cover or for a clinical emergency) and had been able to do so with the current staffing levels. They told us that they reviewed staffing levels twice yearly and they felt the current staffing level was correct. However, they told us they would continue to review this**.** There had been no incidents reported where low staffing was a concern.

The trust used an electronic rostering system to determine staffing numbers and the ward had fulfilled the staffing quota set by this system. However, the parameters used by the trust to set staffing levels, did not include the vulnerability of patients with intensive physical health needs, such as the patients at 2 Woodlands Square. The trust used the following factors to determine staffing levels;

- Staffing demand identified by clinical leads for inpatient areas against the actual worked hours by clinical staff.
- The percentage of the worked hours that have been allocated to Bank and Agency.
- The percentage skill mix of registered and unregistered staff.
- The percentage of newly qualified staff operating on the unit.
- The percentage vacancy factor on the unit.

**Parkside Lodge**

There were three qualified nurses and five health care assistants working on the early shift (7:30am to 3:30pm) and late shift (12:00pm to 8:00pm). The manager explained that the number of health care assistants was dependent on admissions on the ward and changes in patient need such as increases or decreases in observation levels. At night, there were two qualified nurses on shift and three healthcare support workers. The manager explained that this was because the ward was a stand-alone unit with no additional response team to call in emergencies. Shift patterns at Parkside Lodge worked well because the early and late shifts overlapped meaning that between the hours of 12:00pm and 3:30pm, there were high staff levels on the ward to support leave for patients.

The trust supplied training figures for mandatory training compliance; their target for completion was 90%.

Mandatory training for staff included:

- clinical risk,
- duty of candour,
- equality and diversity,
- essential life support,
- immediate life support,
- fire safety level 3
- food safety level 2
- health and safety
- high level personal safety and breakaway
- personal safety with breakaway
- infection control
- information governance
- Mental Capacity Act and Deprivation of Liberty Safeguards level 2
- Mental health Act inpatient
- mental health awareness
- moving and handling advanced and essential
- safeguarding adults level 2
- safeguarding children level 2 and 3
- Trust induction

Levels of mandatory training were below the trust target in some areas. However, the trust target is high at 90%. Parkside Lodge had the lowest levels of compliance with 2 Woodland Square achieving most areas of compliance.

Only 54% of staff had completed clinical risk assessment training at Parkside Lodge. Patients are at risk if staff are unable to protect them by assessing their needs.

At 2 Woodland Square, only 75% of staff had received training in Mental Capacity Act and Deprivation of Liberty Safeguards. The figure was improved, at 81% at Parkside Lodge. The trust target was for 90% of staff to be trained by

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July 2016. This meant that patients were at potential risk of not having their rights upheld. We found low compliance with the Act on 2 Woodland Square, which was because staff had not undertaken the appropriate training.

The trust told us that 79% of eligible staff at Parkside Lodge had undertaken training in moving and handling at any level. This increased risk because not all staff could manage patients with mobility issues safely.

Only 68% of staff at Parkside Lodge had undertaken high-level personal safety training. This meant that not all staff were trained to manage challenging behaviour safely, despite restraint being used on this ward

Compliance with food safety training was low at Parkside Lodge (71%) and 3 Woodland Square 68%. This placed patients at risk of infection from eating food, which staff had not handled correctly because they were untrained.

The trust had a 90% target for compliance with Mental Health Act training, which they had planned to meet by July 2016. None of the wards had met this compliance level. Only 67% of staff at 3 Woodland Square and 70% of staff at Parkside Lodge had completed mental health inpatient training. However, 83% of staff at 2 Woodland Square had undertaken Mental health awareness training; this figure was only 63% at Parkside Lodge but improved to 100% at 3 Woodland Square. The training figures across the service were inconsistent. This meant that not all staff had completed training in the Act and may not have an understanding appropriate to their job role. This may put patients at risk of staff being unable to uphold their rights and provide information and advice.

Only 71% of staff at 3 Woodland Square had undertaken infection control training. We had concerns about infection control practices on this ward, which was because the service had not ensured all staff were trained.

Mandatory training compliance was a concern at previous inspections and the trust continued to be unable to meet their training target, which placed patients at risk of receiving care, which was unsafe.

### Assessing and managing risk to patients and staff

Staff understood the supportive engagement policy and used it to manage patients' individual risk, particularly in relation to ligature points and blind spots throughout the wards. The focus was on engaging with patients rather than observing them and we saw this during our visits to all wards. Parkside Lodge were to begin a pilot scheme in September of using tablet computers with patients on the ward to complete observations where patients could be involved in recording them.

Patient records evidenced staff increasing or decreasing observation levels as risk levels changed. Nursing staff could increase levels of observation but discussed a decrease in levels with the multidisciplinary team. If this needed urgent review, staff could speak with the doctor.

Staff at 2 Woodland Square had not recorded any incidents of restraint in the last six months. 3 Woodland Square had recorded 17 episodes of restraint between 7 March 2016 and 15 June 2016, 16 of these were sitting or standing restraint, which the manager explained, was light touch restraint to move patients to a safer area. One of these episodes was prone restraint. Prone restraint involves staff holding patients on the floor in a face down position.

Parkside Lodge used restraint on 195 occasions, with five patients. Forty-seven of these restraints were supine restraint where staff held patients laid down on their back. Nine of these were prone restraints. National Institute for Health and Care Excellence guidance states that staff should only use prone restraint when it is unavoidable. This is because of the risk to patients of coming to harm due to the compression of the chest used in this technique. Two of the prone restraints involved the use of rapid tranquilisation. Rapid tranquilisation is the use of medication (usually intramuscular) if oral medication is not possible or a patient needs appropriate and urgent sedation with medication. Staff told us that they always used prone restraint to give medication via an injection when a patient refused this. The trust rapid tranquilisation policy (May 2015) did not state that rapid tranquilisation should be given in prone restraint. Staff could use other techniques for rapid tranquilisation, and where working outside of the trust policy.

We reviewed 19 incidents of restraint at Parkside Lodge on the trust electronic system. Staff recorded all incidents in detail and completed body maps to note any injuries to patients from restraint. Staff reduced restraint holds as quickly as possible and released patients from restraint after a short time. Restraint used was proportionate to the level of risk shown by the patient.

2 and 3 Woodland square had not reported any incidents of seclusion from March to June 2016. There had been five

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incidents of seclusion at Parkside Lodge during the same period. Staff kept detailed records of seclusion and two staff (including one nurse) carried out hourly reviews and 15-minute observations. A doctor had attended within the first hour of seclusion.

The ward manager told us that the staff attempted to move people out of seclusion and back to their room as quickly as possible using de-escalation techniques. Of the three episodes we reviewed, one ended after three hours, one after four and a half hours and one after four hours. Staff recorded physical observations; however, they did not record details of a patient's presentation if they refused to comply with observation. We discussed this with the manager on our visit who agreed to discuss this with the staff.

Staff on all three wards used the functional analysis of care environment risk assessment tool and recorded this on the trust electronic system.

**2 Woodlands Square**

Patients had risk assessments on the trust electronic system; however, staff did not print them for client files. This meant that they were not readily available to staff. We saw four risk assessments, which staff had not updated since 2014, June 2015, January 2013 and May 2015. Staff had not linked risk assessments to care plans. For example, a patient had a care plan for treatment of their gastrostomy, but the service had not attached a risk assessment to this care plan.

All patients had individual fire evacuation plans due to their complex health needs and equipment We reviewed ten of these plans and found that staff had not dated three of these. Staff had not updated six of these plans since February 2013 and they had not updated one since 2014. This placed patients at risk as their evacuation needs may have changed since this time and staff would not have correct guidance to follow in an emergency.

**3 Woodlands Square**

We reviewed seven patient records. Staff had completed risk assessments for all patients, which were contained in patient files. Staff had not signed four of the risk assessments and they had not reviewed two patients risk assessments in the last six months. One patient had a risk assessment for the specific use of bed rails, which staff had not updated since 2013.

**Parkside Lodge**

All patient files had an updated risk assessment in place. Members of the multidisciplinary team were using the 'five p's' model of formulation; predisposing factors, perpetuating factors, precipitating factors, presenting problems/risk, protective factors. Formulation is a method of analysis used to inform care and treatment of patients, where a team of professionals discuss a patient's behaviour and make decisions about the reasons for that behaviour.

Blanket restrictions were not present in the service. A blanket restriction is a rule that applies to all patients on a ward and restricts their freedom, regardless of individual risk assessments. However, informal patients at Parkside Lodge did not have their right to leave the ward clearly explained to them. There was no sign telling informal patients of their right to leave as recommended by the Mental Health Act Code of Practice.

The trust had put a search policy in place, in July 2016. The policy stated that

"Reasons to implement a search are indicated for any service user on admission, return from leave or return from absence without leave; also for any Service Users where, following a risk assessment, there is reasonable suspicion that the person may be concealing something harmful or prohibited items.

The search should be implemented to:

- prevent injury/harm to the service user
- prevent injury/harm to others
- maintain security and safety
- prevent banned items coming into the area.

A search is indicated for any service user following a risk assessment and providing there is a reasonable suspicion that the person may be concealing something harmful or a prohibited item."

Staff followed the policy by helping patients returning from leave to unpack their belongings when they returned to the ward after a shopping trip or on admission. Staff locked items away that may cause harm. Staff did not search patients outside these times unless a risk assessment indicated that was necessary.

Training in safeguarding adults was above 90%, although training levels in safeguarding children were lower at 88%

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(2 Woodland Square) 66% (3 Woodland Square) and 81% (Parkside Lodge). Staff knew how to make safeguarding referrals, and showed us the trust safeguarding flow chart. At Parkside Lodge, we saw an example of staff completing a safeguarding referral following a police incident to ensure the police had upheld the patient's rights. Staff made good use of links with other community teams, and discussed safeguarding issues or concerns with them.

At 2 Woodlands square, we saw evidence in two patient files of staff completing body maps on admission after finding bruising on a patient. Staff had written about these in daily notes but had not taken advice or recorded that they had made or discussed safeguarding referrals in these cases.

We reviewed the drug charts of 30 patients across the service, to assess how staff managed medication. The trust reported data that showed there had been 27 medication errors in the service between March and June 2016. On twelve occasions, nurses had not given medications, on five occasions nurses had not signed or dated that they had given medication. On four occasions medication had not been dispensed correctly. Staff had found medications patients had not taken, and left on the ward on three occasions. There were two errors when disposing of medications and one patient was given medication later than prescribed. We found four drugs errors at 2 Woodlands Square and two errors at Parkside Lodge during the inspection. All related to administering nurses not signing that they had given medication. Staff told us that they did not do medication audits and they had not picked up these errors. The trust said that staff reviewed medication cards at handover each day and a weekly medication audit took place, we found that this was not the case.

Five medication cards did not have photographic identification. This meant that staff could become confused about whom they were giving medication. Two patients at 2 Woodland Square had prescriptions for a controlled drug, used to manage severe epileptic seizures. Neither the drug card nor the care plans contained up to date information regarding how to administer this drug. The most recent advice on file for this patient was dated 2008.

We did find some areas of good practice in medications management. Staff spoke to the prescribing GP and family before a patient came to the ward to ensure staff could update patient medication cards and note any changes. At 3 Woodland Square, we reviewed 13 drug cards, and found that all 13 had their ability to consent to medication and legal status recorded. All drug cards on this ward were signed and dated and had updated allergy status.

We observed a medication round at Parkside Lodge. Staff interaction with patients was clear and respectful. Patients were given time to consider taking the medication and staff withdrew and went back later when they refused. Nurses dispensing medication at Parkside Lodge wore a red tabard to indicate to other staff not to disturb them.

Staff were experienced in supporting patients with additional needs other than their mental health needs. Practice in recording additional care plans for mobility needs, equipment and nutritional needs was good.

Only Parkside Lodge had a visitor room available. There were no child friendly spaces on any wards for children visiting. Managers told us that they would consider this on a case-by-case basis. Families did sometimes bring children to visit patients at 2 Woodland Square and would meet in the communal lounge or kitchen with their relative. This did not promote dignity and privacy for the patient.

### Track record on safety

In the period, 1 March 2015 and 23 February 2016 the trust reported 48 serious incidents in total. There were no serious incidents requiring investigation recorded for learning disabilities and autism wards.

### Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and were aware of the electronic reporting system. Managers told us that all nursing staff put incidents on the system and we reviewed records, which showed that this was the case.

When staff reported an incident, they sent it to the ward manager to review and agree an action plan. Staff and managers took part in de-briefs after incidents. For example, staff at 2 Woodland square always had staff debriefs following a patient death. At Parkside Lodge and 3 Woodland Square, staff in multidisciplinary meetings discussed all incidents relating to sedation, restraint or seclusion. The team then analysed the incident to see how the service could learn lessons and reduce the risk of it happening again. Staff discussed concerns about practices or near misses in team meetings to share good practice.

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# Are services safe?

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At Parkside Lodge and 3 Woodland Square, staff offered patients a discussion following an incident. Patients could talk to staff about how they felt staff managed the incident and what they would like to be different in the future. This helped staff and patients identify where triggers for challenging behaviour might be to input into risk assessments and care plans.

At Parkside Lodge, only 28% of staff had attended training in duty of candour. This was 100% at 2 and 3 Woodland Square. However, managers and staff we spoke to were able to explain the meaning of duty of candour and give examples of its use in being open and honest with patients when mistakes made in patient care have resulted in a serious incident.

We did not see evidence that staff were involved in reviewing and learning from trust wide incidents. Staff told us that these reports were available on staff net, the trusts intranet, but they did not have time to look at these. There was a concern that staff could miss important information. The inpatients service as a whole did not meet together to share lessons between wards.

# Are services effective?

**Requires improvement**

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Our findings

### Assessment of needs and planning of care

We reviewed the care and treatment records of 29 patients across the learning disability and autism wards.

**2 Woodland Square**

During two visits to this ward, we reviewed 12 patient care files. Nurses did not document when they updated care plans, so it was unclear whether the care plan contained the most recent information. For example, a patient had an administration care plan for an emergency epilepsy rescue medication written in January 2010. Staff had included outdated guidance in care plans, for example, a patient had gastrostomy guidelines in their file, which professionals had written in in 2003 and 2004, and the same patient had dietician guidelines from 2005 in their file. This put patients at risk because new staff, who did not know the patient, might follow outdated care plans with misleading guidance.

Care plans were person-centred and included the likes and dislikes of the patient. Each patient had brief communication guides in place, showing how they communicated with staff. There were good procedures in place to monitor the physical health of patients. Staff updated adult modified early warning scores and baseline observations on a board in the manager's office for all staff to view.

We saw on our first visit that staff had written in patient care plans that patients liked to go to bed between 6.00pm and 7.00pm. We questioned this, because this was not person centred. One patient told us that they did not like respite, because they had to go to bed before the day shift left, and went to bed much later at home. The carer of another patient told us that their relative did not like the early night time routine. After we raised this concern on our first visit, we re-visited the ward at night one week later, practices had changed and staff had amended care plans to include a more person centred description of each patient's preferred night time routine. Both patients were up in the lounge at the time of our night time visit.

Patient records were stored in paper files, with risk assessments stored on the electronic system. Paper files were stored securely in the nurses' office; however, staff had not locked the cabinet during our visits.

**3 Woodland Square**

We looked at the care files of seven patients using the service. All patients had care plans in place, however the service had not always written these, and took them from the community team's electronic system. This meant that the care plans were not specific to the respite service and not updated after each respite stay. However, care plans were person centred and physical health monitoring was good. Staff updated patients' baseline observations on arrival at respite and updated adult modified early warning score during their stay. Only three of the seven files had health action plans. A health action plan should be in place for all learning disabled adults. It is a personal plan about what a patient needs to stay healthy. It lists any help people may need and is a record of all information about a patient's health needs.

Paper and electronic files were in use and we found them difficult to navigate, with information being stored in different places. Paper files were stored securely in the nurses' office.

**Parkside Lodge**

There were six patients on the ward at the time of the inspection. All patients were detained under the Mental Health Act. We reviewed four patient care records. We reviewed detention paperwork of all patients.

We found that two of the four patients had positive behaviour support plans in place, which the psychologist had written to assist staff to manage challenging behaviour positively. Staff monitored the physical health of patients well. We saw staff complete adult modified early warning scores, and baseline scores, but did not always record these. Staff had only updated these in two patient care records. Patients detained under the Mental Health Act had their detention paperwork appropriately filed. Staff had completed capacity assessments for specific decisions and recorded best interest meetings at multidisciplinary team meetings. However, of the four files reviewed we only found one health action plan in place.

Paper and electronic files were in use and they were difficult to navigate, with information being stored in different places. Paper files were stored securely in the nurses' office.

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## Best practice in treatment and care

The service had not embedded National Institute of Health and Care Excellence guidance in patient care plans such as (NG11) Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015) or Epilepsy Diagnosis and Management (2016). At 2 Woodland Square, care plans referenced out of date guidance.

Only Parkside Lodge prescribed medication to patients and prescribing followed National Institute of Health and Care Excellence guidance. At Parkside Lodge, the psychologist was not offering one to one therapy with patients due to time restraints in the assessment and treatment unit but would refer for community psychological therapy if this was required. The psychologist worked with patients to assess their needs, and provided guidance to staff on managing difficult behaviour and measured treatment outcomes for patients.

Staff received training in positive behavioural support planning, as this was the 'commissioning for quality and innovation' target for this year, set by the commissioners of the service. Staff were also involved in implementing the national 'safe wards' initiative, which includes models for reducing conflict on inpatient wards.

When reviewing incidents, the psychologist used challenging behaviour good practice guidance and discussed this with the multidisciplinary team. Staff at Parkside Lodge also used a monitoring tool for as required medications, to ensure staff thought about the use of medication to reduce overuse on the ward.

The service subscribed to the 'prescribing observatory for mental health'. It runs a programme of national quality improvement audits open to all specialist mental health services in the UK. The aim is to help mental health services improve prescribing practice in discrete areas. In 2015 – 2016 six projects were undertaken;

- Antipsychotic medication in people with learning disabilities
- Antipsychotics for people with dementia
- Prescribing for people with personality disorder
- Prescribing for attention deficit hyperactivity disorder (ADHD)
- Prescribing for substance misuse : alcohol detoxification
- Use of sodium valporate

The service was auditing these areas, and sharing good practice within the team. They had action plans for areas of improvement in each topic.

Staff had considered physical healthcare needs on all wards and were undertaking physical observations and updating this throughout the day. All patients had a baseline observation taken on admission to ensure staff could monitor changes.

The service was not involved in any peer review scheme, which meant it could not share and learn good practice from other services of a similar nature.

At Parkside Lodge, the multidisciplinary team had imbedded outcome measures in practice. Staff used tools such as health of the nation outcome scoring, therapy outcome measure frameworks, and a learning disability specific patient outcome scale to support patients to measure their own progress. Staff discussed outcomes at multidisciplinary team meetings and inputted these into care and discharge plans for patients. The psychologist was leading this work and it was effective for the patients in measuring their recovery and needs. The respite services did not use outcome measures. The manager explained that this was due to the service being respite and therefore not linked to outcome scoring.

## Skilled staff to deliver care

Parkside Lodge had a full range of mental health professionals working on the ward and had links to staff in the community. The multidisciplinary team consisted of a psychologist, psychiatrist, nurses, advocates and occupational therapist. The occupational therapist post was vacant at the time of the inspection.

There was no dedicated speech and language therapist attached to the wards. If the multidisciplinary team identified a clinical need for speech and language therapy, they contacted the community team to assess the patient and provide treatment or advice. The trust told us that they planned to develop a business case for a speech and language therapist in the service.

Professionals were not allocated to patients at 2 and 3 Woodland Square unless patients needed additional support and then staff referred them to the community learning disability teams. The managers told us that this was effective and they had the support they needed. The

# Are services effective?

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service did not have a doctor allocated to the ward. This meant that staff referred patients to generic out-of-hours services if they needed medical help. The ward manager had acted creatively to ensure patients could access support, and had made links with an independent hospice in the area whose doctors offered advice and support as needed.

The general adult mental health rota, on which the learning disability staff appeared, provided medical cover out of hours. The trust told us that the core trainee level doctors, on a rota that covered inpatient units, provided psychiatric cover out of hours. Whilst we had concerns that this meant there was no guarantee that the on call doctor would have learning disability expertise, the trust told us that their out of hours response was in line with other areas.

The service had experienced and qualified staff. However, mandatory training compliance was low across the service and this placed patients at risk of staff supporting them who had not received the correct level of training for their role. All staff had completed the trust induction.

Managers did not regularly supervise staff. Only 46% of staff had received clinical supervision at Parkside Lodge and 35% at 3 Woodland Square. Management supervision rates were higher at 70% and 73%. The service did not give staff opportunity to discuss how to improve their performance and identify training and development needs. This increased risk to patients because there was reduced opportunity for staff to learn and improve practice.

Managers had not given staff annual appraisals as per the trust policy. At 3 Woodland Square 64% of staff had received an annual appraisal, and only 55% at Parkside Lodge. Risk to patients was increased because managers did not regularly update staff on the trust's values and vision, managers had not made them aware of changes required in their practices, and managers had not assessed their performance. The trust target for annual appraisals completed with staff was 90%.

When staff performance did not meet with the trust values and expectations, this was dealt with promptly by the modern matron. We saw evidence of investigations taking place into staff performance issues, and saw that managers de-briefed staff following investigations to improve practice and performance. The service worked closely with staff who reported concerns and whistleblowing. There had been some performance and human resource issues at Parkside Lodge, which had caused staff to leave the service. The trust had managed these concerns at director level.

The trust told us that the service had given staff training in positive behaviour support and in working with patients with autism. We asked the trust to provide figures of the number of staff who had done this, but they were unable to do so.

### Multi-disciplinary and inter-agency team work

Only Parkside Lodge had regular multidisciplinary team meetings. Ward managers from 2 and 3 Woodland Square attended respite panels, where they met with other service managers from inpatient services and members of the community teams to discuss patients and new referrals

Staff from 2 Woodland Square had good links with the community complex and multiple impairment team. The managers of both teams worked closely together and we saw that other professionals such as dieticians, occupational therapists and physiotherapists were visiting the ward and having appointments with patients. Other professionals helped with personal care routines on the wards to enable staff undertake thorough assessments of patient needs. Staff from the respite wards worked closely with other services involved in a patient's life, for example school, college or day services and kept close links to allow smooth transfer of care between services.

Parkside Lodge had an effective multidisciplinary team led by the modern matron, psychiatrist and psychologist. The team met with nursing staff on a weekly basis and we attended one of their meetings. The meeting was thorough and the team discussed each patient, and reviewed care plans, risk assessments, outcomes and incidents. The team also discussed discharge, detention and the mental capacity of each patient. The team invited patients into their own meeting, and for those who struggled to articulate their views, staff spent time with them prior to their meeting with a questionnaire and rating scale of how they were feeling which they discussed at the meeting. The multidisciplinary team invited other professionals such as social workers and advocates to every patient meeting.

We observed a handover meeting on each ward and found that they were timely, accurate, and discussed each patient with the staff team coming on shift. Handovers took place at the beginning and end of each day on every ward.

# Are services effective?

**Requires improvement**

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

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

There were no patients detained under Mental Health Act at 2 and 3 Woodland Square. There were six patients detained under the Act at Parkside Lodge at the time of our inspection.

Only 67% of staff at 3 Woodland Square and 70% of staff at Parkside Lodge had completed mental health inpatient training. 83% of staff at 2 Woodland Square had undertaken Mental health awareness training; this figure was 63% at Parkside Lodge and 100% at 3 Woodland Square. Training levels did not meet the trust target of 90% in all services. This meant that the service had not trained staff well in the act and they may not have an understanding appropriate to their job role. This puts patients at risk of staff being unable to uphold their rights and provide information and advice.

We reviewed the files of six detained patients at Parkside Lodge. Hospital managers' hearings and tribunals were taking place, as they should. Staff automatically called a tribunal for patients who lacked capacity. Staff had read patients their rights under section132 of the Mental Health Act at the right time and used easy read versions with patients who had learning disabilities.

Administration staff filed section 17 leave forms appropriately and struck out old forms. The multidisciplinary team discussed patient's leave arrangements at meetings. Patients told us that the service never cancelled their leave. Staff used leave appropriately to support patients to access services in the local community and prepare for discharge. Section 17 is a part of the Mental Health Act, which tells patients the arrangements staff had made to allow them to leave the ward.

Of the six files we viewed, the service had completed consent to treatment capacity assessments the day after admission. However, staff had not repeated the capacity assessment three months after the start of treatment as per Mental Health Act Code of Practice guidelines. It was clear that informal assessment of capacity was taking place in multidisciplinary team meetings and on patient contact with doctors. Doctors' notes provided evidence of this.

However, none of the files contained the Approved Mental Health Professionals' report. We raised this as a concern following a Mental Health Act monitoring visit in 2015 and practice had not changed since this time.

### Good practice in applying the Mental Capacity Act

Completion of mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards was below the trust target of 90% at 2 Woodland Square (83%) and Parkside Lodge (81%). Staff put patients at risk if they had not upheld their human rights because they were unaware of their responsibilities relating to the act.

Staff were knowledgeable about the act. Staff had completed capacity assessments when patients needed to make specific decisions. Best interests meetings were taking place at multidisciplinary team meetings. Staff invited families and Independent Mental Capacity Advocates to in order to support the patient.

Parkside Lodge staff showed good practice in actively considering whether the legal authority of the Mental Health Act or Mental Capacity Act Deprivation of Liberty safeguards was most appropriate for individual patient circumstances. The team discussed whether they should apply for Deprivation of Liberty Safeguards when they discharged patients. We also saw that staff made an application for a patient who lacked capacity to remain on the ward informally, but was no longer detainable under the Mental Health Act.

Practice in relation to the act was a concern at 2 Woodlands Square. They had undertaken mental capacity assessments with 22 of the 24 patients accessing the service. Seven of the assessments stated that all patients lacked capacity to consent to respite stays and to care and treatment. However, staff had then completed a Deprivation of Liberty Safeguards checklist for these patients, which said that the risk was low. The risk was not low, because patients had equipment such as padded bed rails, shoulder straps, sleep medication, which meant that they were subject to continuous supervision and control, and not free to leave. The ward manager told us that the trust had a plan to make applications, however this was not in place at the time of our inspection. Clear legal authority had not been obtained to care for patients who lacked capacity to consent to their care and treatment and were deprived of their liberty.

Good

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

We undertook observations of staff working directly with patients on all wards within the service. Conversations with patients were at the appropriate level to their understanding. Patients with communication difficulties had communication profiles, which described how they communicated their needs, wishes and feelings and how they liked to be cared for.

We saw examples of staff engaging with patients during observations, rather than this being only a checking exercise.

Staff were responsive to patient needs and we saw staff act quickly to provide care requested by patients. Staff knew patients well and took time to understand their needs. Staff changed activities and outings to suit the needs of patients, and took into account their religious and cultural needs. For example, staff had care planned to take a patient on regular trips to a mosque and had bought puzzles for a patient who enjoyed these.

Staff at 2 Woodland Square were undertaking detailed pre-admission assessments by visiting patients at home and at their daily activities. This was to ensure that staff provided care in a manner the patient liked, and by discussing their care routines with current care providers and the patient's family. However not all areas of patient choice were taken into account and acted upon, for example patients could not access activities they chose as transport was not available, and not all patient's preferred night time routines were initially included in care planning.

We spoke with nine patients across the wards. Patients spoke positively about the way staff treated them. We spoke with 18 carers who praised all of the staff working with their relatives. Carers described staff as kind and caring.

Patient led assessments of the care environment focus on privacy, dignity and wellbeing. Parkside Lodge scored 84% in this survey in 2015 and woodland square 87%, the England average is 86% and the trust overall average is 91%. This meant that the people visiting this service felt that privacy, dignity and wellbeing were positive in this service but not meeting the average for the trust.

### The involvement of people in the care that they receive

Where patients were able to input into their care plans we found that this was happening. Patients were more able at Parkside Lodge and inputted into their care plans.

Staff provided section 132 rights in easy read formats. Staff gave patients easy read forms to complete to feed into their multidisciplinary team meeting and ensure the meeting listened to their view.

At 2 Woodland Square, events and activities were taking place such as carers groups, and parties for patients and carers to get involved with the service. Carers were welcomed into the service and visited relatives whenever they chose. All wards had open visiting times and encouraged families to visit and spend time on the ward.

Staff supported patients to use advocacy services. At Parkside Lodge, there was significant links with advocacy services and the service invited them to all meetings regarding patients.

The trust took part in the friends and family test, which was a survey to gather patient and carer views of the service. This was not broken down into learning disability services. Data provided was for the whole trust from 215 patients in January to March 2016. This data showed that patients reported they felt safe, able to achieve their goals, listened to and part of care planning. We did not see areas on the wards, which contained details about participation in the friends and family test to encourage patients and families to take part.

Staff at Parkside Lodge had started a patient involvement group. There were no patient meetings on other wards. Staff said that this was because of the nature of respite, being a constant change of patients. However, that meant that opportunities for patients to feedback about their stay were limited.

# Are services responsive to people's needs?

Good

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

## Our findings

### Access and discharge

Bed occupancy across the service was low at 48% at Parkside Lodge, 73% at 2 Woodland Square and 23% at 3 Woodland Square. The ward manager explained that bed occupancy was low at Parkside Lodge because they did not accept admissions if the ward was not safe. For example if staffing levels were low or there was an unsettled patient. This was positive for patients, and the managers explained that they did not feel pressure to fill beds when it was unsafe. However, this may affect the local population who may be unable to access beds at Parkside Lodge because the ward was low on staff and not taking admissions. We spoke with one carer who told us that the process of obtaining a bed at Parkside Lodge was long and complex for their relative, even though bed occupancy was low.

The service had two patients who were receiving care and treatment on wards outside the local area. These patients had complex needs, which could not be met by the service, despite low bed numbers.

Bed occupancy was low on 3 Woodland Square because the service rarely used the recovery and rehabilitation service.

The service was responsive to the needs of patients and found beds as needed. The psychiatrist would highlight at risk community patients to the multidisciplinary team each week so that the service could plan inpatient admissions. The service could take emergency admissions but these were rare because the service knew the patient group well, and could respond accordingly.

The service was able to respond to patients needs increasing by moving between wards if required. For example, a patient who needed one to one care and was at risk at Parkside Lodge moved to 3 Woodland Square during their treatment with one to one nursing.

The service reported three delayed discharges at Parkside Lodge for 153, 62 and 43 days. The psychiatrist explained that this was due to delay in finding suitable placements in the community for patients.

The average length of stay at Parkside Lodge was 68 days. This was good, because it was less than the NHS England target of 85 days in 'building the right support'. The service discussed discharge in multidisciplinary team meetings and made plans from admission to reduce risk of patients remaining on the ward too long. The staff supported discharge by offering training to patients' new placements for those who needed specialist care.

### The facilities promote recovery, comfort, dignity and confidentiality

All three wards had a clinic room, however the clinic room at 2 Woodland Square did not contain an examination couch and staff did any clinical interventions in patient bedrooms. At Parkside Lodge, there was a doctors' room for clinical interventions to take place.

Specific activity rooms were not available on any of the wards, although Parkside Lodge was more spacious and had two lounges and meeting rooms where activities could take place. Parkside Lodge was the only ward, which had space for visitors to meet with patients in private. At 2 and 3 Woodland Square, visitors would need to meet with patients in bedrooms or communal lounges, which did not promote privacy and dignity.

Patients at 2 and 3 Woodland Square had access to a garden, which they could use with staff support. There was not open access to the garden because of ligature risks. The garden had a seated area for patients and had a basketball net for patients to use with staff. Patients at Parkside Lodge could also use the garden but only with staff support due to ligature risks.

Staff locked kitchens at 3 Woodland Square and Parkside Lodge which meant patients could not access the kitchen to make food and drinks without staff support. Staff at 3 Woodland Square told us that this was because a patient had scalded themselves. Kitchen use was not risk assessed for each patient, which was restrictive. Staff told us that they supported service users to access the kitchen whenever they chose. The kitchen at 2 Woodland Square was open, however staff supervised patients at all times when in the kitchen.

Patients had access to a phone to make calls, and staff supported this by use of a portable telephone if a patient required more privacy.

Patients on Parkside Lodge were able to personalise their bedrooms. This was not possible within the respite services due to patients only staying for a short time. However, we did see that patients were encouraged to bring items in from home, which would help them feel comfortable during their stay.

# Are services responsive to people's needs?

Good

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

2 Woodland Square did not meet same sex accommodation guidelines as male and female patients shared a bedroom corridor, a communal bathroom, and there was no female only lounge. Staff told us that they reduced risk of loss of dignity because patients never moved between corridors in nightwear and most patients were not ambulant so could access the bedrooms of other patients. If patients were ambulant they were monitored at all time when moving around the ward.

Patients at Parkside Lodge and 3 Woodland Square had access to activities on and off the ward throughout the week. Staff supported patients to access activities in the community using their section 17 leave. The occupational therapist post at Parkside Lodge was vacant at the time of our inspection, but recruitment had started, and the previous worker had left ideas and directions for staff to use in the interim. Patients at 2 Woodland Square continued with their lives as they did when they were at home, so patients continued to attend school, college and day centres. Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged.

### Meeting the needs of all people who use the service

All wards were accessible to wheelchair users, and people with reduced mobility. Specialist equipment was in place at 2 Woodland Square to meet the needs of the patient group using the service such as hoists, and specialist-bathing equipment.

All wards had easy read information posted on the walls and photographic displays of staff on shift to aid understanding to patients of who would be working with them.

We saw evidence that the service was providing easy read information to introduce patients to the wards and to explain the roles of the multidisciplinary team and what might happen during their stay.

Not all staff had received training in using communication methods such as Makaton or British sign language. This meant that some patients could not communicate adequately with staff.

We saw the lunch and evening menus at Woodland Square and Parkside Lodge. There were vegetarian and low fat choices offered to patients at each meal and a wide range of choices. Catering staff changed menus on a three weekly basis for patients. The ward kept fruit and snacks for patients to eat between meals.

### Listening to and learning from concerns and complaints

The service was not working creatively to ensure patients could complain. We did not see easy read complaints leaflets for patients to use. Staff at Parkside Lodge had developed specific documents to work with patients with learning disabilities to ensure they could share their views and wishes about their care and treatment. Staff at Woodland Square did not collate information this way.

The service received two complaints from April 2015 to March 2016. The service upheld one compliant. We reviewed these complaints and felt that the managers handled them appropriately. The complainants had received feedback from another manager, as ward managers never investigated complaints on their ward to ensure an independent view. Where appropriate we saw that the service had apologised for mistakes made, had fed these back to the ward and staff, and had evidenced how they could make changes.

Staff referred complaints to their line manager when they received them, and knew how to handle complaints.

# Are services well-led?

**Requires improvement**

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Our findings

### Vision and values

The trust worked to a vision of 'improving health, improving lives', and a mission statement of 'working in partnership, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives'.

The six values of the trust were:

- respect and dignity
- commitment to quality of care
- working together
- improving lives
- everyone counts.

The trust had posted vision and values information on the wards we visited. Staff awareness of these was limited. However, the trust told us that they embedded the values and vision in performance development reviews, and a consultation had started in April 2016 to involve staff in the writing of these.

Staff worked within the vision and values of the trust; they were respectful and treated patients with dignity and compassion. The services were improving people's lives by providing good outcomes after treatment, and breaks for families to maintain patients living at home. Staff worked together within the wards and made links with community services and other organisations to ensure holistic assessments for the patient that staff did not solely base on their mental health needs.

Staff were positive about local and senior managers. They were able to tell us who their senior managers were. Staff told us that they had visited the ward and board members had visited recently. Ward managers told us that they felt supported by the modern matron and had authority to do their job. They said that the modern matron was open, approachable and accessible at any time to offer advice and support. The modern matron told us that their senior managers were also approachable and supportive.

### Good governance

We found that a number of the issues found across the service related to a lack of consistent governance arrangements on individual wards. These were in areas such as; medication audits, mandatory training compliance and supervision.

We requested additional information from the trust to enable us to make a judgement about the quality of the service. The trust was not able to meet the target of returning this information to us in time. This meant that the information we requested was not readily available and highlighted an issue with the trust governance systems.

The trust supplied training figures for mandatory training compliance; their target for completion was 90%. There were several areas of mandatory training, which did not meet this target. This had an impact on patient care. The trust had not improved training levels to meet their own target since this was raised by the Care Quality Commission as a concern in inspections in 2014 when training in immediate life support was at 50%, although some areas of training had improved since this time, others had reduced.

The trust provided data that showed figures for clinical and managerial supervision were low, as were appraisal rates. This meant that managers were not taking responsibility for ensuring staff are supervised and appraised.

The trust said that staff undertook clinical audits of medication, grab bags, defibrillators, drug cards, consent to treatment and medication checks. We found that these were not effective and that staff had not recognised errors. Staff told us that these did not take place on 2 Woodland Square.

Learning from complaints and incidents was good at service level. The multidisciplinary team meeting discussed incidents, restraints and seclusion at Parkside Lodge, and an analysis of these undertaken to look at lessons learnt. Staff meetings also evidenced that staff discussed incidents, changes and near misses to improve practice. However, we did not see evidence that staff were involved in trust wide lessons learnt. Staff told us that these reports were available on staff net, the trusts intranet, but they did not have time to look at these. There was a concern that staff could miss important information. The inpatients service as a whole did not meet together to share lessons between wards.

# Are services well-led?

**Requires improvement**

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Safeguarding procedures were in place and staff followed these. However, the trust had a Mental Capacity Act and Deprivation of Liberty Safeguards policy, which was not being followed by staff in respite services. This was because patients who lacked capacity were subject to continuous supervision and not free to leave. This meant that they met criteria for Deprivation of Liberty Safeguards and the service had not made these applications.

Staff at Parkside Lodge followed the Mental Health Act policy and procedure. However, the seclusion room had been recently re-designed and did not meet with all criteria in the Mental Health Act Code Of Practice (2015). Staff told us that they were not involved in the design of this room and that they had raised concerns that the door to seclusion was not wide enough. Staff said in team meeting minutes that they found moving patients into seclusion in sideways restraint was complex and dangerous. They said that they had discussed with the senior managers and did not feel that the trust had listened to their concerns.

The service was working towards a target of having all staff trained in positive behaviour support planning by the end of 2016. The service recorded data in admissions, discharges, bed availability, data completeness, length of stay and bed occupancy for 3 Woodland Square and Parkside Lodge. The manager of 2 Woodland Square told us that they did not report into any targets or performance indicators and the trust did not submit any information about performance indicators for 2 Woodland Square. Parkside Lodge and 3 Woodland Square also monitored restraint, seclusion and incident reports to ensure lessons could be learnt from incidents and changes made. Ward managers before completion reviewed all incident reports.

Each ward had a risk register, the ward managers were able to input items on the risk register. The modern matron was able to put items onto the trust risk register following discussion with senior managers.

### Leadership, morale and staff engagement

The trust staff survey in 2015 indicated that some staff were unhappy. The percentage of staff who would recommend the trust as a place to receive care was below the England average of 79%, at 60%.

There had not been a staff survey completed relating directly to learning disability inpatient services. At 2 Woodland Square and Parkside Lodge, staff morale was high. The Parkside Lodge staff team had been through a turbulent time in the last 12 months and we spoke with two nurses who were leaving because of this. The trust had undertaken an investigation due to concerns raised by staff. The investigation involved senior managers up to board level. The service had invited staff to attend feedback and de-brief sessions following the outcome of the report and action plan.

Staff did not report feeling bullied or suffering harassment and told us that they would feel comfortable raising complaints, concerns and whistleblowing if they needed to in order to keep patients safe.

The trust average sickness rate was 4%. Sickness levels at 2 Woodlands Square and Parkside Lodge were higher than this. However, managers reported that these figures were long-term staff sickness, which were not work related. Staff turnover on the wards was lower than it had been at our inspection in 2016.

### Commitment to quality improvement and innovation

The service was not involved in quality improvement programmes and was not working towards accreditation. The modern matron told us that there was a learning disability services inpatient plan in progress, which would outline the future direction of the service and its clinical model. The modern matron wanted to see a better environment for patients, with less noise and that was more autism friendly.

The psychologist at Parkside Lodge continued to use innovative practice to gain feedback from patients and measure outcomes for treatment to improve the quality of the service offered to patients.

The manager at 2 Woodland Square continued to work on an innovative plan to open a respite bed in the service for patients with acute physical illness to avoid lengthy inpatient stays, which are difficult for patients, carers and the acute trust to manage. The manager was preparing information for senior managers to consider, but there was not a timescale for completion of this work.

The manager at 3 Woodland Square was reviewing patient care to re-focus the service for the future. The manager explained that the respite service was not outcome focussed and staff were undertaking reviews with each patient of their goals and what the service hoped to help them to achieve. This process had started during our inspection.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met:<br><br>Patient care plans at 2 Woodlands did not show that staff had updated them. They contained out dated advice and guidance on best practice. This put patients at risk because not all staff may understand their needs or changes to their care. Care plans did not link to risk assessments, and nurses had not updated guidance on using controlled drugs and specific feeding regimes.<br><br>Patient evacuation plans at 2 Woodland Square had not been updated for two years.<br><br>Care and treatment must be provided in a safe way for service users.<br><br>This was a breach of regulation 12 (1) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>How the regulation was not being met:<br><br>The trust had not made Deprivation of Liberty Safeguards (2009) applications for patients using respite services at 2 and 3 Woodland Square and lacking capacity to consent to care and treatment. Patients were subject to continual supervision and control, not free to leave and there was use of restraint such as padded bedsides, wheelchair straps and sedating medication.<br><br>A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. |

This section is primarily information for the provider

# Requirement notices

This was a breach of regulation 13 (5)

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>How the regulation was not being met:<br><br>The service did not offer staff regular supervision and annual appraisal. Only 52% of staff had received clinical supervision. Only 64% of staff at 3 Woodland Square and 55% at Parkside Lodge had received an appraisal. This meant that the service was not giving staff opportunity to discuss how to improve their performance and identify training and development needs. It also meant that the service were not regularly updating staff on the trust's values and vision and guiding them in working towards this.<br><br>Only 54% of staff had completed clinical risk assessment training at Parkside Lodge. Patients are at risk if staff are unable to protect them by assessing their needs.<br><br>At 2 Woodland Square, only 75% of staff had received training in Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009). This meant that patients were at risk of not having their rights upheld. We found low compliance with the act on 2 Woodland Square, which was because staff had not undertaken the appropriate training.<br><br>Only 68% of staff at Parkside Lodge had undertaken high-level personal safety training. This meant that the service did not make sure all staff were trained to manage challenging behaviour safely, despite staff using restraint on this ward.<br><br>Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. |

This section is primarily information for the provider

# Requirement notices

This was a breach of regulation18 (2) (a)

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.