Requires improvement

Mersey Care 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)
RW4W1	Rathbone Hospital	STAR Unit	L13 4AW
RW453	Olive Mount Hospital	Wavertree Bungalow	L15 8LW

This report describes our judgement of the quality of care provided within this core service by Mersey Care 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 Mersey Care NHS Foundation Trust and these are brought together to inform our overall judgement of Mersey Care 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?	**Requires improvement** 
Are services responsive?	**Requires improvement** 
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

Contents

Summary of findings

Overall summary

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

- We were concerned about staffing levels at the STAR unit and the impact of this on patients and staff.
- Staff had not had sufficient training in a range of areas essential to this core service, including autism awareness, learning disability awareness, epilepsy and communication skills.
- At Wavertree Bungalow, not all patients with epilepsy had an epilepsy care plan. Patients who required moving and handling assistance did not have written assessments or plans for this.
- We undertook short observations at both services and noted negative interactions with patients at times and that staff did not always follow support plans.
- At the STAR unit and Wavertree Bungalow activities were not always taking place as planned.
- We noted observation records were not fully completed, with gaps where staff had not recorded observations.

However:

- Wards were clean and well furnished.
- Infection prevention practice was good.
- Positive behavioural support plans and risk assessments were well completed and comprehensive.
- Patients and carers gave positive feedback about staff at the services.
- At the STAR unit, a well equipped sensory room was available on the ward and well used.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because

- Staffing levels at the STAR unit were too low and could affect patient safety.
- At the STAR unit, only 60% of qualified staff had completed immediate life support training.
- There were occasions where medicines were not available in a timely fashion at the STAR unit.
- Some medical equipment was out of date at the STAR unit.

However:

- Ward areas were clean and tidy, with furniture in a good state of repair.
- Nurses had completed personal emergency evacuation plans for patients who would need assistance in an emergency.
- Staff at both locations showed good awareness of safeguarding and knew how to raise alerts and we saw evidence of this in records.
- Positive behavioural support plans and risk assessments were well completed and comprehensive.

Requires improvement

Are services effective?

We rated effective as requires improvement because

- At Wavertree Bungalow, two patients with epilepsy did not have epilepsy care plans
- At Wavertree Bungalow, patients' moving and handling assessments and plans lacked sufficient detail.
- Appraisals had not been completed for all staff.
- Staff at the STAR unit had not completed specialist training necessary for their roles.

However:

- Positive behavioural support plans were in place for three patients at the STAR unit who needed these.
- Both services used one page profiles which gave a brief summary of important information about each patient.
- Regular away days took place for staff at each service four times per year.
- Staff completed capacity assessments and Deprivation of Liberty Safeguard applications had been made for all patients who required these at Wavertree Bungalow.

Requires improvement

Summary of findings

Are services caring?

Requires improvement

We rated caring as requires improvement because

- We noted some negative staff interactions with patients during observations.
- We observed poor interactions with one patient, particularly a lack of verbal reassurance when assisting with dietary and moving and handling needs.
- We observed two episodes of physical affection which were poorly managed at Wavertree Bungalow.
- A short observation at the STAR unit showed staff were not fully following a positive behavioural support plan for one patient.
- Community meetings at the STAR unit were ineffective.

However

- We observed some positive staff interactions with patients
- Patients at the STAR unit told us that staff were helpful and respectful.
- Carers gave positive feedback about care at Wavertree Bungalow.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because

- At the STAR unit and Wavertree Bungalow activities were not always taking place as planned.
- At STAR unit, communication aids did not include all necessary symbols and were not always located with the patients who used these.
- The environment at the STAR unit was not always suitable for patients with sensitivity to noise.

However:

- At the STAR unit, a well equipped sensory room was available on the ward and well used.
- Both services were wheelchair accessible and had adapted bathrooms.
- Patients and carers knew how to complain.
- Important information was available in easy-read format

Are services well-led?

Requires improvement

We rated well-led as requires improvement because

- There were no systems in place to monitor the quality of observation records.
- Staff allocation sheets were destroyed each week, which made it difficult to identify staff who had not completed records.

Summary of findings

- Applications for Deprivation of Liberty safeguards were not being recorded by the trust or notified to CQC.
- We received mixed feedback from staff about morale and support.

However:

- All staff reported feeling able to raise concerns with managers.
- Managers at the STAR unit were working towards quality network accreditation.
- Staff identified with the trust vision and values
- There were clear lines of communication between staff, managers and the wider trust.

Summary of findings

Information about the service

Wavertree Bungalow is based at Olive Mount Hospital. It is an inpatient service that provided 24 hour support for adults with a learning disability and complex health needs. The unit comprises four beds for respite breaks and one emergency or assessment bed. The unit is a nurse led service. The unit offers 34 nights per year for 37 patients.

The Specialist Treatment, Assessment and Recovery (STAR) unit is based at Rathbone Hospital and provided 24 hour inpatient care to patients with learning disabilities and additional needs who may be detained under the Mental Health Act. It is a mixed gender nine bedded unit.

These services were inspected as part of a comprehensive inspection in June 2015. At that time, CQC served a requirement notice in relation to consent issues at Wavertree Bungalow. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the current inspection, these concerns had been addressed.

Our inspection team

The team was led by:

Head of Inspection: Nicholas Smith, Head of Hospital Inspection, Care Quality Commission

Team Leaders: Lindsay Neil and Sharon Marston, Inspection Managers, Care Quality Commission

On 23 March 2017 we visited both services, this was an announced visit. The sub team on 23 March 2017 comprised: two CQC inspectors and one specialist nurse advisor. The team were joined by a pharmacist inspector during the inspection of the STAR unit.

On 30 March 2017 we visited both services, this was an unannounced visit. The sub team on 30 March 2017 comprised: two CQC inspectors and one CQC inspection manager.

Why we carried out this inspection

We undertook an announced focused inspection of Mersey Care NHS Foundation Trust because there had been a significant change in the trust's circumstances. The trust had acquired Calderstones NHS Foundation Trust on 1 July 2016.

We also planned this inspection to include high secure services (a new core service) and to assess if the trust had addressed some of the areas where we identified breaches of regulation at our previous inspection in June 2015 (published October 2015).

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 these services, including data requested from the trust.

During the inspection visits the inspection team:

Summary of findings

- Visited both locations at the two hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with six patients who were using the service.
- Undertook observations at both services using the short observation framework for inspection tool.
- Spoke with the managers for each of the wards and the modern matron responsible for the service.
- Spoke with 11 other staff members including nurses, medical staff, occupational therapy staff, housekeeping staff and a pharmacist.
- Attended and observed two hand-over meetings.
- Reviewed feedback from 10 carers provided by the trust and spoke to two carers by telephone.
- Looked at 17 treatment records of patients.
- Carried out a specific check of the medication management on both wards, including reviewing 17 medication cards.
- Reviewed observation records at the STAR unit.
- Reviewed a variety of other documentation including minutes of meetings and incident reports.

What people who use the provider's services say

Patients at the STAR unit told us that staff were helpful and respectful. Patients said staff would knock on doors before entering their bedrooms.

We received feedback from carers at Wavertree Bungalow, which had been collected by the trust carers lead at a carer's forum. Carers gave positive feedback about the cleanliness of the accommodation, food and dietary needs, good communication, medicines management and staff and manager support.

Good practice

Four times per year, Wavertree Bungalow closed for two days. This allowed staff to hold a whole team away day for training, good practice sessions and a whole team meeting on one of the days. On the other day, staff would cover shifts at the STAR unit to enable their staff to have a whole team away day with a similar focus including a whole team meeting.

Team briefs were used effectively to disseminate information to staff, including ward changes and information, learning from investigations and incidents and sharing good practice. These were used at both sites on a monthly basis between whole team meetings every three months.

The model of care at Wavertree Bungalow was for health based respite and examples were given where this may be to assess and support with developing mental health issues or for interim care following acute general hospital stays. There had also been instances when patients were admitted to assess for emerging dementia. Assessment of functioning over a period of time in a familiar environment is suggested good practice in the assessment of dementia (Royal College of Psychiatrists and British Psychological Society "Dementia and People with Intellectual Disabilities: Guidance on the assessment, diagnosis, interventions and support of people with intellectual disabilities who develop dementia" 2015).

All staff at the STAR unit had been trained in positive behaviour support, and a positive behaviour support coach was allocated to the STAR unit for one day per week. Having all staff trained is compliant with NG11 Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015).

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staffing levels are sufficient to manage levels of patient observation at the STAR unit.
- The provider must ensure that staff complete observations as per the trust policy in terms of duration and recording at the STAR unit.
- The provider must ensure sufficient qualified staff complete immediate life support training at the STAR unit.
- The provider must ensure there is a system to monitor clinical stocks and expiry dates at the STAR unit.
- The provider must ensure that moving and handling plans are completed for all patients with moving and handling needs at Wavertree Bungalow.
- The provider must ensure that sufficiently detailed epilepsy care plans are completed for all patients with epilepsy at Wavertree Bungalow.
- The provider must ensure all staff have an appraisal.
- The provider must ensure that all staff receive regular supervision as per the trust policy.
- The provider must ensure that specialist training required to enable them to carry out their role is available to staff.
- The provider must ensure that positive behavioural support plans are followed.
- The provider must consider how to safely manage patient-initiated physical affection at Wavertree Bungalow.
- The provider must ensure that all patients have access to meaningful activities and planned community leave as part of their weekly programme.
- The provider must ensure that where communication aids are required, these are accessible to the patient and staff.
- The provider must ensure there is a system of recording additional training including when this has taken place and who attended.
- The provider must review the monitoring systems for recording training data and deprivation of liberty applications and authorisations.
- The provider must submit notifications to CQC to advise of authorised Deprivation of Liberty Safeguards applications.

Action the provider SHOULD take to improve

- The provider should ensure that community meetings at the STAR unit are meaningful by recording attendees and acting on patient feedback.
- The provider should consider how they might better meet the sensory needs of people with autism on the STAR unit.
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- The provider should consider how they might better meet the sensory needs of people with autism on the STAR unit.

Mersey Care 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
STAR Unit	Rathbone Hospital
Wavertree Bungalow	Olive Mount Hospital

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.

The STAR unit was registered to care for patients detained under the Mental Health Act. Wavertree Bungalow does not admit patients detained under the Mental Health Act and is not registered for this.

A Mental Health Act review visit was completed in October 2016 at the STAR unit. At that visit, actions had been raised in relation to ensuring patients were informed of their rights under the Act, displaying of information about the advocacy service, capacity assessments in relation to treatment and activity provision.

At this inspection, we found that there was evidence of patients being informed of their rights read regularly. Information about the advocacy service was available and capacity assessments in relation to treatment were in place in the records we reviewed. Activity provision was still a concern and is discussed later in this report.

We found overall good adherence to the Mental Health Act Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found overall good adherence to the Mental Capacity Act and saw good examples of capacity assessments, best interest decisions and best interests meetings. We saw that

patients were referred to the local authority when a deprivation of liberty was suspected and that applications were pursued with the local authority who were inundated with applications over the last year.

Wards did not report their Deprivation of Liberty Safeguards applications centrally to the trust or to CQC.

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

The STAR unit had moved location since it was last inspected. The ward was set out with day and communal areas arranged around a main corridor. Staff undertook zonal observations in areas of the ward and there was a high level of individual observations at the time of this inspection. Wavertree Bungalow was comprised of individual bedrooms and communal areas and staff were able to observe patients effectively.

STAR unit had undertaken a ligature point risk assessment and plans were in place to mitigate ligature risks. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The STAR unit had anti-ligature bedroom furniture and anti-ligature en suite bathroom taps and shower fittings. There were potential ligature points on door handles, taps and window latches at the Wavertree Bungalow and these were identified in the ligature point risk assessment. There was a clear management plan in place on how to minimise this risk. Patients admitted to this unit were severely disabled and had mobility difficulties, therefore staff assessed patients as being a low risk of ligature use.

Both units provided mixed sex accommodation. At the STAR unit, all bedrooms were en-suite. A female only lounge was provided in the female area of the ward. In addition, the ward had a shared lounge and dining area. At Wavertree Bungalow, there was one main communal lounge and dining area. Patients privacy and dignity was maintained at Wavertree Bungalow as staff assisted patients to access their bedrooms and to use the bathroom. There were always staff present in the communal areas to ensure patients were safe.

Both locations had clean, well maintained clinic rooms. Staff regularly checked emergency equipment and emergency medication.

There was no use of seclusion at either service.

Nurses completed regular infection control audits at both locations. Actions needed were reported to managers. Managers actioned issues raised, for example, at Wavertree Bungalow, ordering new mattresses when it was noted that the old mattresses had been stained by the cleaning solutions used. Medical devices in use, for example, hoists, were checked weekly for maintenance and disinfected. There was a procedure at Wavertree Bungalow for methicillin resistant staphylococcus aureus screening for patients admitted who had percutaneous endoscopic gastrostomy feeding in place.

Nursing staff in both settings carried alarms to summon assistance. There were also nurse call buttons in bedrooms on the STAR unit. When nurses activated personal alarms at the STAR unit a loud alarm sounded throughout the ward until this was deactivated by staff.

Safe staffing

We were concerned that the staffing levels at the STAR unit were too low and could affect patient safety. The establishment staffing level was not sufficient to manage the level of observations. Managers were unable to secure sufficient additional staff to reach this establishment level.

At the time of inspection, staffing establishment was for nine staff on duty for day shifts and seven staff on duty at nights. The establishment was for two qualified nurses for day shifts and one qualified nurse at night. This establishment was higher than normal because of increased observation levels.

There were four patients who were subject to continuous observations by staff (level three observations) and of these, two patients were subject to observations by two staff at all times. This meant that six staff were always allocated to continuous observations, and allocation sheets showed that staff were regularly allocated to more than the two hours observation specified as the maximum in the trust policy. We saw allocations where staff were on continuous observation duty for seven hours, often their whole shift. This meant that staff were not able to take breaks and it would be difficult to maintain high levels of concentration and responsiveness for such long periods. The ward manager at the STAR unit assisted staff in observation duties and witnessing medication rounds due to current ward acuity.

The duty rota for the STAR unit showed that in the week prior to inspection, there were regularly fewer than nine

staff, with only two day shifts out of fourteen having nine staff. At the unannounced inspection visit, there were seven regular staff on duty and a member of staff had been transferred, part way through the shift, from another ward on the site for the shift to cover. The occupational therapist was assisting ward staff and patients rather than being able to undertake structured activity due to the acuity of the ward. The ward manager was also assisting at times with observations and witnessing medication rounds.

We reviewed the STAR unit leave records for the week prior to inspection and noted that all patients who had used leave during the week had been escorted by community staff or families. There was one leave description completed for a local shop leave for one patient with staff, but at the handover it was noted this had not gone ahead due to staff shortages and staff had later purchased the items the patient had wanted. All patients had escorted leave granted but we did not see leave being planned for those who did not have family or carers to support leave. Activities were also not happening on the ward according to the weekly planner, for example, a scheduled exercise group did not take place on the day of inspection although a scheduled dance group was taking place at the further unannounced visit.

Information provided by the trust showed that as of 7 February 2016 that there were 1.28 whole time equivalent qualified nurse vacancies, which was 8% of the qualified nurses. There were 1.4 whole time equivalent nursing assistant vacancies, which was 5% of the nursing assistants. The services had a staff turnover rate of 8% in the 12 months between 1 January 2016 and 31 December 2016.

The average sickness rate for this core service in the 12 month period was 0.08% which is significantly better than the trust average of 7%. STAR Unit had a marginally higher sickness rate than Wavertree Bungalow at 0.09% compared to 0.03%.

The provider had mandatory training requirements for all staff. Compliance with safeguarding adults and children training at level 2 and level 3 were below 75%. At the STAR unit, only 66% of qualified staff had completed immediate life support training; the figure at Wavertree Bungalow was 100%. This meant that there may not be adequately trained staff on duty in the event of an emergency. There was mitigation for this in that high risk interventions, such as prone restraint and the use of rapid tranquillisation, rarely occurred at the STAR unit. There was a doctor on site at the hospital who would respond if there was a medical emergency. A doctor was present if rapid tranquillisation was being used, this was part of the trust policy.

The STAR unit had used rapid tranquillisation on three occasions in the previous year, with no rapid tranquillisation used at Wavertree Bungalow.

Medical cover at the STAR unit included the consultant and junior medical staff during the day and hospital on site cover at night and weekends. At Wavertree Bungalow, staff would contact the consultant team during the day who were based at a nearby hospital and the on call cover overnight who were also based at the nearby hospital. If the need was more in relation to physical health, the staff had good links with the local GP service and could temporarily register patients or they would seek advice from the patient's own GP, including arranging staff and transport for appointments if needed.

Assessing and managing risk to patients and staff

There were no reported episodes of seclusion or segregation in the last twelve months at this service from data provided by the trust although one patient had been managed during 2016 in segregation at the STAR unit.

There were 131 incidents of restraint during this period of which STAR Unit had the highest number of restraint incidents with 130. Three of these incidents of restraint resulted in the use of rapid tranquilisation. There was only one incident of prone restraint, which also took place at STAR Unit. This had been for a short period of time and was appropriately reported. Prone restraint is where an individual is held in a restraint position on their front. This position poses an increased risk for the safety of the individual.

In both settings, when patients were admitted, staff completed risk assessments within 48 hours and updated these regularly.

Nurses had completed personal emergency evacuation plans for patients who would need assistance in an emergency.

There were necessary and proportionate blanket restrictions in place to ensure patient safety at STAR unit, for example, restricted access to lighters. The Mental Health Act Code of Practice defines blanket restrictions as "rules or policies that restrict a patient's liberty and other rights,

Requires improvement

Are services safe?

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

which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application." The Code's position is that blanket restrictions should be avoided unless they are necessary and proportionate.

Staff in both services were trained in management of violence techniques which emphasised the use of de-escalation techniques. The STAR unit had been a pilot site for trust implementation of the "No Force First" approach, a trust wide restrictive practice reduction programme.

Staff at both locations showed good awareness of safeguarding and knew how to raise alerts. We saw instances in clinical records were staff had raised safeguarding alerts. Staff also had access to a trust safeguarding team for advice.

This core service made 12 adult safeguarding referrals to the local authority during 2016, 11 of which were made at STAR Unit and one at Wavertree Bungalow.

Medicines management practice at Wavertree Bungalow was satisfactory. Doctors completed prescription cards clearly, with the exception of two cards, which did not include allergies. However, prior to each admission, staff obtained GP records including updated prescription information and allergies to enable medicines reconciliation, so this information was available and was stored with the prescription card.

At the STAR unit, we found out of date syringes, out of date glucometer calibration solution and out of date glucometer test strips. Once highlighted, staff immediately removed these and disposed of them. We noted a medicines reconciliation error for a patient when admitted, which meant that treatment was not continued for two medicines (one an antidepressant) for two days although the clinical notes did not indicate any symptoms suggestive of withdrawal. One patient had not received a prescribed medicine for three days following prescription, as the medicine was not obtained from pharmacy. One prescription card had an unsigned box for a medicine, which should have been given on the previous evening. We checked the stock and spoke with staff. We found that the medication had been given but not signed for.

Medicines management training figures were low, with 65% staff overall having completed controlled drugs and high risk medicines training (30% at STAR and 100% at Wavertree), medicines calculations (11% at STAR and 100% at Wavertree), safe and effective use of medicines (0% at STAR and 100% at Wavertree) and medication witness training (15% at STAR and 63% at Wavertree).

Both clinic rooms were tidy and well organised. Nurses regularly checked emergency equipment and medicines. Nurses checked fridge temperatures to ensure medicines were stored safely. There was a care plan and monitoring for one patient prescribed lithium.

Both services had procedures for children visiting.

Track record on safety

Between 01 November 2015 and 31 October 2016, the STAR unit reported two serious incidents, which required investigation. One incident related to a death and the other was regarding serious self harm. Both investigations had been completed to trust timescale.

Reporting incidents and learning from when things go wrong

Staff were aware of how to report incidents. Staff used the electronic system to report incidents. At the STAR unit, incidents involving restraint were compiled into a weekly report for the ward manager as part of the no force first initiative so that themes and trends could be analysed. Managers discussed feedback from incidents at team meetings.

We reviewed two investigation reports from 2016. Investigation reports were completed with clear terms of reference, investigation and actions. In one of the investigation reports we reviewed, we found that staff on duty had not been interviewed, their experience and training had not been reviewed and there were no actions for the ward to take, despite issues being identified in the body of the report.

The second report recorded a thorough investigation and analysis of the incident including a multidisciplinary meeting held with staff and carers following events to debrief and evaluate.

Incidents and findings were fed back to staff at both services using regular team briefs sent to all staff and in team meetings. The trust created quality practice alerts, which were emailed to staff summarising learning as a result of incidents. These were on display in the staff rooms and summarised in team briefs.

Requires improvement

Are services safe?

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

Duty of Candour

Managers were aware of the duty of candour and their responsibilities. There had been no recent incidents that met the threshold for duty of candour, but we saw minor incidents were immediately discussed with patients and carers when necessary, with apologies and reassurance given.

Two serious untoward incidents were investigated in 2016, with a thorough investigation and actions noted from one and full involvement of family members. The second investigation report did not include any contact with relatives or involvement in the investigation.

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 four treatment records at STAR unit. Care plans were put in place shortly after admission in three records reviewed. In one record, there had been no admission care plan and the first care plan was not put in place until 12 days following admission.

All patients at the STAR unit had a paper file entitled "My file". We reviewed all seven of these. These were kept by staff but patients accessed these and they contained care plans, nursing individual session notes and positive behavioural support plans where applicable. Four files had one page profiles which were a summary of important information, including likes and dislikes and physical health needs. A "getting to know you" sheet was completed with patients and carers, which covered likes, dislikes and important information although only one file had a completed one of these.

Care plans at both settings were in a standard format from the electronic system. We did not see any care plans in an accessible format, for example, using symbols, plain English or larger font to meet the accessible communications standards.

Positive behavioural support plans were in place for three patients at the STAR unit who needed these. These were well completed and detailed.

STAR unit staff used communication aids for two patients, however staff were not using these consistently. Two patients used picture based communications. One patient's picture file was with them and staff at the first inspection, but at our unannounced inspection was not with the patient or staff. A Velcro planner to map out the day's activities visually was blank. The second patient's picture file was not located with them or the staff at the initial inspection but was available to them the following week and we did see some staff use of these in making choices for drinks and food. When staff were asking one of the patients about using the sensory room we asked to see the symbols that were used for this, and a symbol for the sensory room could not be found by staff.

The Royal College of Speech and Language Therapists (2014) recommends five good practice standards around speech, language and communication in specialist learning disability settings which centre around assessment, staff skills, creating communication opportunities and supporting individuals to be involved in their care. We saw that staff at times were encouraging communication and saw some plans which included communication strategies.

At Wavertree Bungalow, we reviewed ten care records. Records were maintained on the electronic system with a paper file additionally available for staff to refer to. Nurses devised acute care plans based around the activities of daily living model and these were reviewed at each admission.

In these care plans there were reference to health conditions, for example, epilepsy, but in two files we reviewed, there was not sufficient detail to guide staff in managing specific patients' epilepsy. There was no detail about types of seizures, frequency, duration, antecedents and warning signs and no guidance as to when to use rescue medication, despite this being prescribed for both patients. National Institute for Health and Care Excellence guidance (Epilepsies: diagnosis and management, guideline 137) includes the need for plans for the use of emergency medication and has specific guidance for use. We did see one detailed epilepsy care plan in one record.

Staff also identified mobility issues in acute care plans and one page profiles, but there were no plans which offered specific guidance and detail to staff in how to safely assist patients. In one patient's health passport, we noted medical history which would impact on moving and handling but this was not captured elsewhere. The Manual Handling Operations Regulations (1992) says there should be a specific assessment of an individual's moving and handling needs which includes situations, how many staff are needed, how moving and handling should be done and what equipment is needed and how this should be used. Of the ten records reviewed, we identified nine where a moving and handling plan was needed, and they were not in place. We were told that when patients were first admitted, bespoke training took place with a moving and handling trainer to demonstrate best practice for that patient but we could not find this information then documented to ensure all staff were aware of the plan.

A physical examination was completed as part of the admission process at the STAR unit. At Wavertree Bungalow, nurses completed a physical health check and body maps at each admission.

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.

At both settings, nurses made clinical entries and completed care plans on an electronic system. Support workers did not have access to the system. Paper files were available in both services with copies of information from the system stored, for example, care plans and section documentation.

Best practice in treatment and care

A clinical psychologist worked on STAR unit two days a week, which was in line with British Psychological Society recommendations for acute mental health care pathways (2012). The clinical psychologist provided individual evidence-based formulation and interventions. They also led reflective practice sessions with nursing staff. There was no psychology provision to Wavertree Bungalow as this was not required for a health based respite service. If staff felt that psychology input may be needed this would be raised with patients' community teams.

We saw evidence of multidisciplinary planning with the involvement of speech and language therapy along with the clinical team involved in devising positive behaviour support plans.

Both services offered good access to physical healthcare, including speech and language therapy input and dietician support. Wavertree Bungalow was able to assist families in accessing dental, chiropody and optician services, including patients being visited at the service by a local optician if needed.

Staff at the STAR unit and Wavertree Bungalow had developed good working relationships with the learning disability liaison nurses employed by one of the acute NHS Trusts, to enable planning and information sharing related to planned outpatient and inpatient treatment as needed.

Nursing staff completed a malnutrition universal screening tool for each patient when admitted. Nutrition and hydration needs were planned, including when patients required specific diets or thickened fluids. Staff at Wavertree Bungalow had twice yearly refresher training in managing percutaneous endoscopic gastrostomy feeding. This is a way of introducing food, fluids and medicines directly into the stomach by a thin tube through the skin and into the stomach.

Nursing staff at Wavertree Bungalow completed Waterlow assessment scales, an assessment of risk for pressure sores, at each admission and had access to tissue viability support as needed.

The trust undertook clinical audits to ensure that malnutrition universal screening tools were being completed and to ensure risk assessments were being completed at each admission. Both services scored highly on these audits.

Nursing staff completed audits on the ward, for example, monthly infection control audits.

Skilled staff to deliver care

At the STAR unit, there was a full multidisciplinary team including medical staff, an occupational therapist, psychology input two days per week and a pharmacist who visited weekly. At Wavertree Bungalow, a doctor visited weekly. Because Wavertree Bungalow was a respite service, other professionals involved with the patients would see them at home or with regular carers. Both services offered good access to physical healthcare, including speech and language therapy input and dietician support. Wavertree Bungalow was able to assist families in accessing dental, chiropody and optician services, including patients being visited at the service by a local optician if needed.

There were stable staff teams at both locations and both services employed registered learning disability nurses.

Not all permanent nursing staff received regular appraisal. The STAR unit had the highest appraisal rate at 83% followed by Wavertree Bungalow at 53%.

In terms of clinical supervision rates for non-medical staff, the average clinical supervision rate for the core service was 65%. At the STAR Unit 94% of staff were receiving clinical supervision as per trust policy, whereas Wavertree Bungalow sat at 45%.

The trust provided their revalidation information and indicated that one doctor was revalidated in the last 12 months with no further revalidations outstanding.

Whole team meetings took place on a three monthly basis when each of the services had an away day. The away days were also used to complete training, for example, at the STAR away day in January 2017 there had been training for the whole team in positive behaviour support and plans. A positive behaviour support coach had been recruited by the trust and was allocated to the STAR unit for one day per week.

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.

In terms of specialist training, at their away days, staff at Wavertree Bungalow completed additional training in percutaneous endoscopic gastrostomy feeding, physical health monitoring, moving and handling and dysphagia training.

All staff at STAR unit had been trained in positive behaviour support, and a positive behaviour support coach was allocated to the STAR unit for one day per week. Having all staff trained is compliant with NG11 Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015).

At the STAR unit, staff told us they had not completed learning disability awareness training, autism training, communications skills training or epilepsy training. There had been a session in August 2015 for staff at STAR unit and Wavertree Bungalow, which covered learning disability awareness and aspects of autism and communication. Epilepsy training had been delivered five years previously, but current trust guidance was for staff using or likely to use rescue medication to receive annual training in this. Staff also identified receiving no mental health training although there had recently been an elearning package devised (all qualified nursing staff were registered learning disability nurses).

We were told that bespoke training would often be delivered by specialists at both services as needed, for example, epilepsy training from a specialist neurology service for specific patients, but dates and names of those who attended were not routinely being recorded. At the STAR unit, records were not kept of training delivered on away days. This meant that additional training and skills were not being captured.

At the forthcoming away day for the STAR unit, a session on autism awareness was planned.

Multi-disciplinary and inter-agency team work

There were weekly multidisciplinary meetings at the STAR unit. Patients at the STAR unit also had care and treatment reviews arranged. Care and treatment reviews are multidisciplinary reviews held to ensure progress is being made during a patient's admission and to assist in developing discharge plans for patients with learning disabilities in hospital. At Wavertree Bungalow, nursing staff would attend community review meetings as necessary.

We observed two nursing handovers at the STAR unit. One was an effective handover, with patients discussed respectfully although no notes or records were made during this handover. Another handover was observed that was detailed but included one negative comment regarding behaviours. This handover was documented but staff were noted signing daily handover entries that they had not had time to read. An individual handover from nursing staff to an additional member of staff during the shift was noted to be thorough and positive.

There were good working relationships at both services with community teams and community organisations, including effective transition planning at the STAR unit where patients had plans in place for individual community care packages.

At the STAR unit there were regular meetings with the commissioners for services and the local authority, with a focus on admission and discharge pathways and planning.

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

Managers at the STAR unit and Wavertree Bungalow reported that all staff had completed Mental Health Act training.

Patients were not detained under the Mental Health Act at Wavertree Bungalow.

Staff were aware of the Mental Health Act and its application to their role, for example, in relation to leave.

Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached to medication charts where applicable.

Patients had their rights under the Mental Health Act explained to them on admission and routinely thereafter. Easy read versions of rights leaflets were available.

Detention paperwork was stored on the electronic records system.

Patients had access to an independent mental health advocate and staff were clear on how to access advocates.

The trust had an audit schedule for checking consent to treatment documentation, legal rights and section 17 leave.

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.

Good practice in applying the Mental Capacity Act

Managers at the STAR unit and Wavertree Bungalow reported that all staff had completed Mental Capacity Act training. Staff at Wavertree Bungalow had also received additional face to face training at an away day in June 2016.

Staff demonstrated knowledge of the Act and Deprivation of Liberty Safeguards and its relevance to their role and patient group.

Ward records showed that the STAR unit had made one and Wavertree Bungalow had made 37 Deprivation of Liberty Safeguards applications in 2016. STAR unit's application had been authorised by the local authority, but Wavertree Bungalow's had not yet been assessed. The manager at Wavertree Bungalow had made arrangements with the local authority for these applications to be progressed and maintained contact with the local authority.

At Wavertree Bungalow, staff had completed capacity assessments for each admission. Staff completed specific decision capacity assessments when needed. Best interests meetings had been convened with family and professionals when needed, for example, when considering covert medication. There were detailed minutes and plans derived from these.

At the STAR unit, we saw detailed capacity assessments and best interests meeting minutes for a proposed medical treatment. This included regular reviews of capacity and the decision made.

At the STAR unit, one patient had been admitted informally in an emergency situation during a night shift. This patient had a capacity assessment in place stating that they did not have capacity to consent to admission. Staff acted appropriately by completing a Mental Health Act assessment as soon as practicable.

Requires improvement

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 used the short observation framework for inspection tool during this inspection. CQC inspectors use this tool to capture the experiences of people who use services who may not be able to express this for themselves. We undertook just under an hour and a half of observations at Wavertree Bungalow on two separate occasions. Of a total of 37 interactions, 22 were positive, for example, staff acknowledging interactions, enabling patients and showing acceptance and warmth. 12 were noted to be negative interactions, with the majority being ignoring patients.

There was some inappropriate language noted, for example, staff talking to patients using childlike language. Additionally we observed poor interactions with one patient, particularly a lack of verbal reassurance when assisting with eating and drinking and moving and handling, despite this being part of their care plan. We observed staff discussing patients due to be admitted in the presence of other patients, breaching confidentiality. We observed two episodes of physical affection initiated by patients but returned by staff. These were poorly managed, with no strategy evident in care records to model alternative behaviour/distraction or diversion planned for staff.

A short observation at the STAR unit showed staff were not fully following a positive behavioural support plan for one patient in terms of using visual cues and pictures, using Makaton and not speaking about past enjoyed events. The plan also included guidance for staff in using picture cards to enable choices, which was not seen in practice. For example, the patient was not offered a choice of fruit. Staff chose the fruit and then fed it to the patient. When we queried this in terms the positive behaviour support plan, staff explained there was a risk of choking if the fruit were to be eaten in one but other options had not been considered. The cards for this patient were not with them when we asked to see them. Similarly, another patient who used picture cards was being encouraged to use the sensory room on the ward, but a card for the sensory room could not be found by staff when this was queried.

We interviewed six patients during this inspection. Patients at the STAR unit told us that staff were helpful and respectful. Patients said staff would knock on doors before entering their bedrooms. At Wavertree Bungalow, staff respected patients' dignity, for example, by ensuring doors and curtains were closed if undertaking personal care.

We received feedback from carers at Wavertree Bungalow, which had been collected by the trust carers lead at a carer's forum. Carers gave positive feedback about the cleanliness of the accommodation, food and dietary needs, good communication, medicines management and staff and manager support.

We spoke to one carer from the STAR unit and the carer representative, who were positive about the nursing staff and their involvement in the care of their relatives. The carers had some reservations about the environment, which related to the building design and previous function as a psychiatric intensive care unit and less space than the previous location in terms of activity groups.

Staff knew the patients in their care well and spoke of them in a caring and respectful way.

The involvement of people in the care that they receive

At the STAR unit, patients received a comprehensive patient information booklet on admission. This included easy read language and larger font describing the routine of the ward, key professionals including pictures and information about the Mental Health Act and advocacy. An information pack was provided to carers at Wavertree Bungalow outlining the ward routine and key staff. This also included useful additional information about local community provision with adult changing facilities.

Patients at the STAR unit told us about their care plans. Two patients told us they had not been involved in devising these. However we did see that patients had completed likes and dislikes forms with staff which were used in devising care plans. One patient had been involved in devising a plan with staff to assist budgeting and health promotion. At Wavertree Bungalow, carers had been involved in devising care plans. There were no accessible care plans seen as part of this inspection.

An advocacy service was available to patients at the STAR unit and this was included in the patient information pack and on posters displayed on the ward.

Requires improvement

Are services caring?

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

Monthly community meeting minutes for the STAR unit did not include a list of attendees. Similar issues were raised by patients with no action noted. There were no community meetings at Wavertree Bungalow although regular monthly carer meetings were held with good attendance noted.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

Both locations had admission criteria and pathways. At Wavertree Bungalow, there was a set pre-admission procedure involving assessments and pre-admission visits. Referrals could be made by professionals or carers. Once accepted, patients were allocated 34 nights respite over the year and there were several ways this could be taken, with flexibility for individual circumstances or emergencies. Ordinarily the fifth bed at Wavertree Bungalow was kept for emergency or unplanned stays as needed. Because stays were pre-planned, named nurses could be allocated to work with their patients and gender mix of staff could be planned in advance.

The model of care at Wavertree Bungalow was for health based respite and examples were given where this may be to assess and support with developing mental health issues or for interim care following acute general hospital stays. There had also been instances when patients were admitted to assess for emerging dementia. Assessment of functioning over a period of time in a familiar environment is suggested good practice in the assessment of dementia (Royal College of Psychiatrists and British Psychological Society "Dementia and People with Intellectual Disabilities: Guidance on the assessment, diagnosis, interventions and support of people with intellectual disabilities who develop dementia" 2015).

At the STAR unit, planned admissions were arranged via the community teams or other health services, for example, mental health wards and accident and emergency departments. Planned admissions were discussed with the multidisciplinary team, the purpose of admission was clarified and agreed and an initial care plan put in place. Out of hours, at nights and weekends, admitting decisions were made by the on-call psychiatrist in liaison with the on call modern matron, which meant that there was not always a clear plan in place to ensure the individual's needs would be met.

Between January 2016 and December 2016 average bed occupancy for the STAR unit was 91% and for Wavertree Bungalow was 93%.

Patients at Wavertree Bungalow stayed for an average of 4days for each period of respite. The average length of stay for discharged patients at the STAR unit was 84 days.

Between January 2016 and December 2016, there were two delayed discharges at the STAR unit. Delayed discharges are when a patient no longer needs to be in hospital but cannot be discharged as there is not an appropriate community placement available. At this inspection, there were two patients at the STAR unit identified as having delayed discharge.

Discharge plans were in place for all patients at the STAR unit and patients we spoke with were aware of their plans.

The facilities promote recovery, comfort, dignity and confidentiality

At Wavertree Bungalow, there was a shared communal area including a dining and lounge area. Patients had access to their own bedrooms for privacy. Visits would take place in the main lounge area.

At the STAR unit, there were two lounge areas, a space for religious needs and quiet areas on the ward. There was a well-stocked arts and crafts room. A sensory room on the ward, equipped with soft padding, adjustable lighting and sensory equipment, for example, fibre optics light tubes, was available on the ward and well used.

Patients had access to their own mobile phones at the STAR unit following a risk assessment and a communal handheld phone was also available for patients to use to make private calls.

At both settings, there was access to outdoor garden areas.

Patients raised no concerns about food.

Patients had access to hot drinks and snacks. Patients could access the kitchen at STAR unit with staff or staff made drinks for patients.

At both settings, patients were able to personalise their bedrooms with their own belongings. At the STAR unit, there was lockable storage in bedrooms for patients to store valuables.

At both settings, we had concerns about activity provision.

At Wavertree Bungalow, a ward activity planner for the day of the inspection listed arts and crafts. Two patients were present during the visit with three support staff on shift, and we observed one patient colouring in. This was in a colouring book that had already been completed and the patient was re-colouring pictures. There was no activity taking place with the other patient, despite care plans indicating several individual activities that the patient

Are services responsive to people's needs?

Requires improvement

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

enjoyed. There were no individual activity planners for patients. A number of patients went out during the day at Wavertree Bungalow, to their existing day provision including day services.

At the STAR unit, patients told us that they spent time watching TV, listening to music and playing cards. One patient raised concerns that they were unable to cook on the ward, despite having cooked for themselves regularly prior to coming into hospital. One patient described frustration regarding being unable to go on leave due to staffing levels, and feeling stuck on the ward.

We saw two individual planners with entries including watching TV, shower or bath and attending ward round. Planners were adapted from the weekly ward planner and included ward based groups. One to one named nurse sessions were not planned on these. We did not see any leave planned on individual activity planners.

One patient's picture-based daily visual planner was blank, with no pictures added, despite the use of this being encouraged within the positive behavioural support plan.

The ward activity planner for the week of inspection included several ward based groups including music and exercise groups. An exercise group was on the planner for the afternoon of 23 March 2017 when we inspected, but this did not take place. A dance group was taking place at the time of our second visit, 30 March 2017. However, we were told and it was noted in community meetings that music and exercise sessions were coming to an end due to funding and there were no plans to replace these. The ward activity planner also included two ward rounds and a community meeting, despite these not being held weekly.

Occupational therapy staff at the STAR unit were concerned that due to observation levels on the ward, they were not able to run groups or complete individual assessments and spent time attending to immediate needs, for example, assisting with laundry and making drinks. Staff told us that nurse led activities were often cancelled due to low staffing levels.

Leave records for the week before inspection indicated that patients who had used leave had used this with family members or community team staff. One leave record indicating that ward staff had accompanied a service user to the local shop was not signed, and on further checking, this had not gone ahead as it could not be facilitated, and staff had later been to the shop and purchased the necessary items for the patient.

Meeting the needs of all people who use the service

Both services were equipped with level access for wheelchair users and had adapted bathrooms available. Hoists were available in both services and at Wavertree Bungalow patients used their own slings from home. This was good practice, as they are prescribed for each individual patient and it reduced infection control risks.

Large pictorial signage was in use at the STAR unit to help patients identify particular rooms.

Information leaflets were available in easy read format for medicines, complaints and Mental Health Act. The patient information booklet for STAR unit also included easy read and pictorial information. Easy read information was also displayed on the ward.

We were concerned about communication methods and staff understanding of these. On the STAR unit, we saw staff were using a picture based communication system. In one instance, staff were observed telling one patient they were going to the sensory room. We asked if a picture was available for this as this was a regular timetabled activity but this could not be found. The cards for another patient were not with him when inspection staff asked to see them. We did not see any patients assessed as needing communication aids at Wavertree Bungalow.

There were no records of staff communication training, for example, if staff understood alternative and augmentative communication including symbols, Makaton or sign language.

An assistant practitioner at the STAR unit was the communication champion and liaised with speech and language therapists, completed communication skills checklists and compiled Makaton training packs for staff.

The STAR unit had patients who were on the autistic spectrum, and the environment was difficult to control to ensure a low noise, low stimulus environment. For example, when nurses activated personal alarms a loud, piercing alarm sounded throughout the ward until this was

Are services responsive to people's needs?

Requires improvement

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

deactivated by staff. This had also recently been identified at a care and treatment review for one patient whereby the positive behavioural support plan was well devised but difficult to implement in the ward environment.

Interpreters were not currently needed at either service but staff were aware of how to access these if needed.

The menu choices at the STAR unit included religious choices and vegetarian meals. At Wavertree Bungalow, staff cooked meals according to patients' identified likes and dislikes and dietary needs, for example, softened diets or thickened fluids.

Listening to and learning from concerns and complaints

Patients and carers we spoke with knew how to complain and there was easy-read information about how to complain visible on the wards.

In the 12 month period from 1 January 2016 to 31 December 2016, the two services received a total of three complaints, of which two were not upheld and one was still ongoing. Wavertree Bungalow received two out of the three complaints of which one was still ongoing.

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

Staff we spoke with were aware of the trust visions and values.

The trust's vision is "to be recognised as the leading organisation in the provision of mental health care, addiction services and learning disability care."

The trust has four values which are:

- Continuous improvement
- Accountability
- Respect
- Enthusiasm

Staff were aware of the trust's initiatives, for example, perfect care and the no force first approach. There had been presentations as part of team away days about no force first and reducing restrictive practices.

Staff were able to identify senior managers in the trust and told us they had visited ward areas. The ward managers and modern matron for the service knew their services well.

Good governance

At the STAR unit, the allocation of staff to continuous periods of observation duties had been identified but it had been difficult to address this. The service was seeking guidance as to how these observations could be more effectively identified as increased support and ways to change the planning and recording of this.

There was no system in place to check observation records once completed. We found numerous records with gaps where no information was recorded. Allocation sheets for observation duties were destroyed each week, meaning it was not possible to identify who was allocated for some of these missing records.

The STAR unit had a high level of acuity and complexity at the time of this inspection, evidenced in the difficulties with observation levels, recording and staffing. Staff did not always feel they had the necessary skills and knowledge to manage the complexity of the current patients at the STAR unit.

Managers had identified that the current service specification did not reflect the current ward level of acuity and were looking to revise this with commissioners.

The trust targets for supervision and appraisal were not being met at both services. In terms of clinical supervision rates for non-medical staff, the average clinical supervision rate for the core service was 65%. The appraisal rate across the two services was 68%.

We noted discrepancies in the trust recording of mandatory training levels and data held by ward managers. We were told that some staff had completed training twice but their records did not show as completed. Ward managers had taken screenshots of completed training for staff as the system was not showing their training as complete. This was particularly around some of the recently introduced elearning modules.

The wards did not report their Deprivation of Liberty Safeguards applications centrally to the trust or to CQC. The trust provided information around the number of Deprivation of Liberty Safeguards applications they have made between 1 January 2016 and 31 December 2016 and indicated that none had been made. CQC received no direct notifications from the trust for these wards during this period. However, ward records showed that the STAR unit had made at least one application and Wavertree Bungalow had made 37 Deprivation of Liberty Safeguards applications in 2016. STAR unit's application had been authorised by the local authority, but Wavertree Bungalow's had not yet been assessed. The ward manager at Wavertree Bungalow had maintained communication with the local authority about these applications and plans were in place to progress these.

The trust had submitted information that there had been no use of segregation at the STAR unit during 2016, but CQC had been notified of one patient who was being treated in segregation for part of the year.

Team briefs were used effectively to disseminate information to staff, including ward changes and information, learning from investigations and incidents and sharing good practice. These were used at both sites on a monthly basis between whole team meetings every three months. The trust also distributed quality practice alerts to share learning with staff across the whole organisation with the aim of improving practice and care delivered.

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.

Ward managers had key performance indicators within their services, including the completion of malnutrition universal screening tools and risk assessments within 48 hours of admission.

Ward managers felt they had sufficient authority and autonomy within their settings. At the STAR unit, a ward clerk provided administrative support for the manager and ward staff.

Ward managers were able to escalate concerns and potential risks to their matrons who were then able to add items to the risk register. The trust had identified two risks on their board assurance framework relating to wards for people with a learning disability and/or autism and inpatient wards more generally, including delays in access to beds and a risk that the trust would be unable to provide sufficient staffing on wards.

We felt the arrangements in place for away days for both services was good practice and allowed for team building, team meetings and additional training. These were planned well in advance to allow booking of appropriately skilled speakers and trainers. The training and skills development from away days was captured at Wavertree Bungalow and added to staff training records but this was not replicated at the STAR unit.

Leadership, morale and staff engagement

The average sickness rate for this core service in 2016 was 0.08% which is significantly better than the trust average of 7%. Star Unit had a marginally higher sickness rate than Wavertree Bungalow at 0.09% compared to 0.03%.

Figures provided for 2016 showed vacancy rates for qualified nurses at STAR Unit were 16% while there was an over establishment of nurses at Wavertree Bungalow. Vacancy rates for nursing assistants ranged from 3% at STAR Unit to 8% at Wavertree Bungalow, and the number of vacancies were highest between January and March 2016, decreasing across the remainder of the year as positions were filled. There were four support workers at the STAR unit working their notice period to leave at the time of inspection and one qualified nurse recruited but who had not yet started work.

We received mixed feedback from staff about morale and support. Staff at Wavertree Bungalow felt there was good morale and managerial support. At the STAR unit, one member of staff reported feeling valued and listened to, but two staff reported poor morale, and all reported frustration about the level of observations and the effect on patients and staff. One member of staff reported feeling the ward was unsafe and the complexity of patients too high.

Some staff also reported feeling there was no career progression and no support for development. Two staff at the STAR unit reported a lack of training and knowledge around learning disability, autism, communications skills, dementia awareness and mental health.

All staff reported feeling able to raise concerns with managers. Staff felt able to raise suggestions or changes within the ward environments. We saw several changes to practice made at the STAR unit following suggestions by qualified and student nurses.

Managers reported feeling supported by senior managers and the modern matron had organised a regular meeting each week for the managers of his services to review the status of services and share issues and difficulties.

Leadership training was available to qualified nurses and managers. There were no staff currently undertaking this.

There were no bullying or harassment cases being investigated at either service. The trust reported that since 13 February 2016, there were no cases in which staff had been suspended or placed in supervised practice within the service.

Ward managers we spoke with were aware of the duty of candour, the level of incident that would constitute meeting the duty of candour threshold and actions that would need to be taken.

Commitment to quality improvement and innovation

The STAR unit had previously been accredited by the accreditation for inpatient mental health services scheme prior to moving location. The service was now working towards quality network accreditation, which has replaced the inpatient mental health accreditation scheme.

Both services had student nurses on placement who were undertaking learning disability nurse training.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect During observations, inspectors witnessed poor interactions with patients, particularly of patients being ignored. There were poor interactions observed when managing the care of a patient who required verbal reassurances. Staff discussed other patients due to be admitted in front of patients. There were two inappropriate physical affection interactions noted during observations. We witnessed interactions using child-like language towards patients. Positive behaviour support plans and care plans were not followed by staff. Communication strategies and aids were not used by staff with patients who required these. We observed negative descriptions of patients' behaviour used in a nursing handover. This was a breach of 10(1) and(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were no written moving and handling plans in place for patients at Wavertree Bungalow.

This section is primarily information for the provider

Requirement notices

Not all patients with epilepsy at Wavertree Bungalow had a detailed epilepsy care plan.

There was out of date clinical stock at the STAR unit and medicines had not been prescribed as part of reconciliation at admission. There had been delays for two patients in starting treatments as medicines were not available and one patient's medicines were not signed for.

This was a breach of 12(1)(2)(a)(b)(c) and 12(2)(g)

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

Staff were undertaking up to seven hours of observations without a break. The trust policy is for no longer than two hours. There were also gaps in the observation records where no entries were made and this had not been identified.

There was no system to record additional training undertaken by staff at the STAR unit.

This was a breach of 17(1) and (2)(b)(c)

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

There were not sufficient numbers of staff on duty to manage the level of observations.

Only 60% of qualified nurses had completed immediate life support training at the STAR unit.

This section is primarily information for the provider

Requirement notices

Staff had not had sufficient training in a range of areas essential to this core service, including autism awareness, learning disability awareness, epilepsy and communication skills.

Staff were not receiving regular supervision or an annual appraisal as per the trust policy.

This was a breach of 18(1) and (2)(a)