

# Cygnets Whorlton Hall

## Quality Report

Cygnets Whorlton Hall  
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Date of inspection visit: 12 to 17 May 2019  
Date of publication: 25/09/2019

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

### Ratings

Overall rating for this location	Inadequate	
Are services safe?	Inadequate	
Are services effective?	Inadequate	
Are services caring?	Not sufficient evidence to rate	
Are services responsive?	Not sufficient evidence to rate	
Are services well-led?	Inadequate	

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

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

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

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

# Summary of findings

## Overall summary

We inspected Whorlton Hall due to concerns raised by the Panorama programme into alleged abuse of patients at this hospital.

We have taken enforcement action against the registered provider in relation to our concerns about this location. This limits our rating of safe, effective and well-led to inadequate, and the rating overall for Whorlton Hall to inadequate.

At the time of inspection, there was an ongoing police investigation which meant we were not able to review all documentation, or speak to patients, so whilst we inspected these domains, we were unable to rate the caring and responsive.


- The service did not have effective systems in place for ensuring that staff adhered to the provider's policies and procedures. This included adherence to safe practice in administering 'as required medication' and monitoring patients after rapid tranquilisation, keeping records that demonstrated that staff were suitable to work at the hospital and undertaking the daily environmental risk checks.
- Staff used physical restraint on 1348 occasions in the year leading up to the inspection. They also used rapid tranquilisation on three occasions. The Resuscitation Council (UK) recommends that staff using restraint or rapid tranquilisation should receive training in immediate life support as a minimum standard. Staff at Whorlton hall had not received this training.
- The provider's restrictive interventions reduction programme had not been effective. Staff continued to use physical restraint frequently and the number of times it was used had increased.
- Staff did not follow best practice with respect to mental capacity and best interests. Rather than undertake mental capacity assessments on a decision-specific basis, staff made over-arching assessments which covered a number of different areas. Staff made decisions in patients' best interests for patients assessed as lacking capacity. However, a number of the best interest documents failed to record how the patient, family, carer or advocate had been involved in the best interest decision making process.
- We found a number of instances where staff were not following the care plan. These included decisions about the gender of staff carrying out observations on patients and the importance of using Makaton and other communication aids.
- Recruitment procedures established to ensure staff employed in the service were of good character or had the necessary qualifications, competence, skills and experience required to carry out their role were not operated effectively.

However:

- Care plans were personalised, holistic and recovery orientated.
- Staff ensured that patients had access to physical health care services.
- There was access to a well-equipped activity hub at the hospital which enabled a range of educational and social activities to be facilitated.

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate	

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# Summary of findings

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Inadequate 

# Cygnnet Whorton Hall

## Services we looked at

Wards for people with learning disabilities or autism

# Summary of this inspection

## Background to Cygnet Whorlton Hall

Cygnet Whorlton Hall is an independent hospital which provides assessment and treatment for men and women aged 18 years and over living with a learning disability and complex needs. The hospital also cares for people who have additional mental or physical health needs and behaviours that challenge and patients that are detained under the Mental Health Act. The service has 22 beds and at the time of the inspection there were 7 patients receiving care and treatment.

The hospital has been registered with the CQC since September 2013 and is registered to provide the following regulated activities:

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

The hospital had a registered manager who was the service manager, as well as an accountable controlled drugs officer who was the regional nurse consultant. At the time of our inspection the registered manager had been suspended and we were not able to meet with them.

The location has been inspected by the CQC on five previous occasions.

CQC undertook a comprehensive inspection in September 2017, when it rated Whorlton Hall as good overall and good in all five key questions. We undertook an unannounced, focused inspection March 2018. This inspection was in response to whistleblowing concerns that we received in relation to staffing, patient safety,

culture and incident monitoring. Whilst we did not re-rate Whorlton Hall at this inspection, we found the provider to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 18: staffing. Agency staff were not receiving appropriate training relevant to their roles and there was no system in place to monitor this, and not all staff were receiving individual supervision in line with the policy and supervisory bodies.
- Regulation 17: good governance. There were no systems in place to assess, monitor and mitigate the risks relating to the health and safety of service users and others who may be at risk arising from the carrying on of the regulated activity, specifically associated with the lack of risk assessments related to staff working excessive hours, in some cases 24-hour shifts.

In July 2018, CQC undertook an unannounced Mental Health Act monitoring visit. There were no issues reported as a result of this visit.

At the time of the most recent inspection, there was an ongoing police investigation into alleged abuse of patients at this hospital. A large number of staff had been suspended, including the registered manager and the deputy manager. The hospital was working with commissioners to transfer all the patients to suitable alternatives. The service has been none operational since 22 May 2019.

## Our inspection team

The team that inspected the service comprised of three CQC inspectors including one pharmacy specialist.

Due to the short notice of this inspection, it was not possible for us to include an expert by experience as a member of the team.

# Summary of this inspection

## Why we carried out this inspection

We inspected this service as a result of concerns that were raised about the safe care and treatment of patients.

At the time of the inspection there was an ongoing police investigation into alleged abuse of patients at the hospital. A large number of staff had been suspended, including the registered manager and the deputy manager.

## 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?

During the inspection visit, the inspection team:

- reviewed six care plans, risk assessments and care and treatment records of patients
- spoke with one service manager
- spoke with two qualified nurses
- spoke with two health care assistants
- spoke with three multi-disciplinary team members
- reviewed seven medication records

- reviewed a small sample of incident records
- looked at staff training records
- carried out general observations and 3 structured observations using the Short Observational Frameworks for Inspectors tool
- looked at arrangements for access to advocacy
- looked at staffing levels
- reviewed five staff files
- looked at a range of policies, procedures and other documents relating to the running of the service.

During our interviews with staff, due to the ongoing police investigation, we did not ask questions that directly related to the allegations that had been made against staff at the hospital. We took this approach to ensure that we did not cause any disruption to the ongoing police investigation.

## What people who use the service say

Due to the ongoing police investigation at the time of this inspection we did not speak to patients or carers.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We have taken enforcement action against the registered provider in relation to our concerns about this location. This limits our rating of safe to inadequate.

- Staff frequently used physical restraint and had used rapid tranquilisation on three occasions in the year leading up to the inspection. The Resuscitation Council (UK) recommends that staff using restraint or rapid tranquilisation should receive training in immediate life support as a minimum standard. Staff at Whorlton hall had not received this training.
- On two occasions that staff had used rapid tranquilisation, they had not recorded the necessary physical health observations.
- The provider's restrictive interventions reduction programme had not been effective. Staff continued to use physical restraint frequently and the number of times it was used had increased.
- In the month leading up to the inspection, staff had not completed the daily environmental risk assessment checks on half of the occasions they should have done.
- The manager who was present at the time of the inspection did not usually work at Whorlton Hall and could not locate information about the skills, training and experience of agency staff. This meant that they could not assure themselves that these staff were suitable. This was because there was no system in place to access this information. The information was provided to the inspection team at a later date.
- There were a number of different case files for each of the patients. In a service with high
- staff turnover that frequently employed agency staff, this potentially posed a risk to the quality and safety of patient care. Whilst we noted that a large number of agency staff used by the hospital were used on a regular basis, it would be difficult for staff, and in particular new staff, to find specific items of information.
- Two of the seven patient bedrooms were completely bare apart from a bed. During the inspection, staff were unable to provide evidence as to why this was the case. Evidence submitted after the inspection did not provide adequate information to indicate that the rooms were bare due patients' sensitivities. Some information provided referenced patient sensitives but

Inadequate





# Summary of this inspection

no there was no evidence that this had been regularly reviewed or assessed. In addition, there were no decision specific capacity assessments or best interests decisions documented about these particular aspects of care.

## Are services effective?

We have taken enforcement action against the registered provider in relation to our concerns about this location. This limits our rating of effective to inadequate .

- Staff did not follow best practice with respect to mental capacity and best interests. Rather than undertake mental capacity assessments on a decision-specific basis, staff made over-arching assessments which covered a number of different areas. Staff made decisions in patients' best interests for patients assessed as lacking capacity. However, a number of the best interest documents failed to record how the patient, family, carer or advocate had been involved in the best interest decision making process.
- Although, in general, care plans were personalised, holistic and recovery orientated, we found a number of instances where staff were not following the care plan. These included decisions about the gender of staff carrying out observations on patients and the importance of using Makaton and other communication aids.

However:

- Staff ensured that patients had access to physical health care.

**Inadequate**



## Are services caring?

We have not rated caring because we did not speak with patients or carers during this inspection due to an ongoing police investigation.

We found the following issues that need to improve:

- One patient had a care plan that specified that staff should communicate with the person using Makaton and visual aids. We observed two occasions when staff were not taking this approach.
- We found one occasion where staff did not safeguard confidential information appropriately.

However:

- Staff informed and involved families and carers appropriately.
- Staff made sure that patients had access to an advocate and encouraged them to make use of them.

**Not sufficient evidence to rate**



# Summary of this inspection

## Are services responsive?

At the time of inspection, there was an ongoing police investigation. Due to the investigation, we were unable to gather sufficient evidence to rate this key question.

- Patients had their own ensuite bedrooms and those that required it had access to a private lounge.
- Patients were encouraged to make use of the community they lived in where this was appropriate.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- There was access to a well-equipped activity hub at the hospital which enabled a range of educational and social activities to be facilitated.

Not sufficient evidence to rate



## Are services well-led?

We have taken enforcement action against the registered provider in relation to our concerns about this location. This limits our rating of well-led to inadequate.

- Effective governance systems were not in place to ensure that all policies and procedures were adhered to by staff working at the hospital.
- Despite the measures put in place at the service to reduce restrictive practices, there were ineffective processes in place to ensure that staff minimised the use of restraint; the number of uses of restraint was increasing at the hospital and remained high.
- There were a number of concerns relating to medication administration and monitoring found throughout our visit.
- There was not a system in place to ensure that daily environmental risk checks were being carried out, this meant that gaps in these checks went unnoticed by the provider.
- We could not find information that we were looking for in patient records. We felt this could make it difficult for new staff to deliver safe and effective care and treatment.
- There were several examples of discrepancies contained within different elements of the care records.
- We found a detailed forensic history contained within one patient record, which was easily accessible to all staff.
- The system in place to allow the management team to effectively allocate agency staff on duty was poorly maintained and therefore ineffective.

Inadequate



# Summary of this inspection

- Recruitment procedures established to ensure staff employed in the service were of good character or had the necessary qualifications, competence, skills and experience required to carry out their role were not operated effectively.

However:

- Patients were given the opportunity to be involved in the development of services through regular resident meetings and a regional peoples parliament.

# Detailed findings from this inspection

## Mental Health Act responsibilities

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

All staff had received training in the Mental Health Act.

Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and the hospital had access to a named Mental Health Act lead.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy services. The provider had a contract with a local provider and they came into the service once a week to meet with patients. There were posters up around the hospital and in easy read format; they explained that advocacy services could also be contacted by phone if required.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated as required and recorded that they had done so. This was done in line with the provider policy and the Mental Health Act.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Patients and staff were able to have a copy of these forms where it was necessary. Examples of leave granted that we looked at were for a variety of activities including attending appointments, social activities and visits with families and carers.

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

Staff stored copies of patients' detention papers and associated records correctly so that they were available to all staff that needed access to them. The service had separate paper files for each patients' Mental Health Act paperwork and they were organised and easy to navigate.

There were no informal patients staying at the hospital when we visited.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety percent of staff had had training in the Mental Capacity Act.

There were no deprivation of liberty safeguards applications made in the last 12 months at this hospital.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it and knew where to get advice from if they needed it.

Whilst staff assessed patients' capacity and documented this, we did not see evidence that these were carried out on a decision specific basis. Instead, over-arching capacity assessments were carried out with patients which covered a number of different areas.

When patients lacked capacity, staff made decisions in their best interests. However, a number of the best interest documents contained generic statements about a patient's diagnosis, for example, the patient is autistic. From the evidence we saw there was also a lack of patient, family, carer or advocate involvement in the best interest decision making process.

We saw an example of a Mental Capacity Act audit that had been carried out the previous year. This audit stated the hospital was 94% compliant in this area. However, it highlighted a number of capacity assessments that had not been reviewed.




# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Inadequate	N/A	N/A	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not rated	Not rated	Inadequate	Inadequate

# Wards for people with learning disabilities or autism

Safe	Inadequate 
Effective	Inadequate 
Caring	
Responsive	
Well-led	Inadequate 

## Are wards for people with learning disabilities or autism safe?

Inadequate 

### Safe and clean environment

#### Safety of the ward layout

The provider expected staff to carry out a daily risk assessment of the care environment. The records showed that, in the month leading up to this inspection, staff had made only about one-half or the required number of checks.

The ward layout was complex. The hospital had a number of different floors, landings and corridors. Despite this, staff were able to observe all parts of ward where patients were because the patients were on a high level of observation. All patients were on at least one to one observation when not in their bedrooms. Observation levels were based on individual risk assessments and carried out in accordance to care plans.

There were potential ligature anchor points (a point that somebody might use to tie something to) which were identified on a ligature risk assessment. Staff had mitigated the risks adequately either with individualised risk assessments or environmental risk assessments, including safe staffing levels. The ligature risk assessment was kept where it was available to all staff.

The ward complied with guidance on eliminating mixed-sex accommodation, all patients had their own bedroom with an ensuite bathroom. Female patients had bedrooms in a separate part of the hospital. There was also a well-equipped female only kitchen and lounge which male patients were not permitted to enter.

Staff had easy access to alarms and patients had easy access to nurse call systems. We saw evidence of staff responding promptly to patient and staff requests for support. We also saw that regular checks were carried to ensure the system worked correctly.

#### Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained. We saw maintenance records which evidenced a fast response to reported issues.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.

Staff adhered to infection control principles, including hand washing.

#### Safe staffing

Establishment levels: registered nurses (WTE) - 7

Establishment levels: support workers or equivalent (WTE) - 90

Number of vacancies: registered nurses (WTE) - 0

Number of vacancies: support workers or equivalent (WTE) - 49

The number of shifts\* filled by bank or agency staff to cover sickness, absence or vacancies in 12-month period

7511 (The provider told us this was on average 50% of the total number of shifts)

The number of shifts\* NOT filled by bank or agency staff where there was sickness, absence or vacancies in 12-month period -0

Average staff sickness rate (%) in 12-month period - 2.45%

Average staff turnover rate (%) in 12-month period - 51.8% (inclusive of bank staff)

# Wards for people with learning disabilities or autism

The hospital had enough staff and they appeared to know patients well. Despite the high number of vacant posts, when we visited the hospital there were only a small number of patients admitted.

There was a minimum of two nurses on duty during the day and one nurse on duty at night. The number of support workers on duty was based on the current patients' needs and anticipated observation levels. Two nurses and two health care assistants were always supernumerary of patient observation levels, during the day, to allow for additional support to be offered where it was required. There was a high ratio of unqualified health care assistants to nurses on shift at the hospital.

The ward manager could adjust staffing levels daily to take account of case mix, this was made possible by the use of agency staff.

The provider confirmed that bank or agency staff were used in the last 12 months to fill half of the total number of shifts in order to maintain safe staffing levels. When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. Although the hospital used a high percentage of agency staff, a large number of the agency staff had been used on a regular basis over a long period of time so knew the service and patients well.

However, when we asked to see records of agency staff so that we could examine their skills, completed training and length of service, these records were not easily accessible. The manager who was present at the time of the inspection did not usually work at Whorlton Hall and could not locate information about the skills, training and experience of agency staff. This meant that they could not assure themselves that these staff were suitable. This was because there was no system in place to access this information. The information was provided to the inspection team at a later date. We asked the provider to respond to our concerns regarding this system and they did so immediately, putting in place a system that allowed easy access to this information. We tested the system once it was rectified and it was able to provide the necessary information required for staff to plan the shifts.

A qualified nurse was always present or able to assist when needed in communal areas of the ward.

Staffing levels allowed patients to have regular one-to-one time with their named nurse or key worker. Staff shortages rarely resulted in staff cancelling leave or activities.

We could not evidence that staff had up to date disclosure and barring checks in place, including agency staff.

There were enough staff to carry out physical observations.

## Medical staff

The hospital had adequate medical cover. There were 1.5 whole time equivalent consultant psychiatrists in post, although, both consultant psychiatrists also had patients at one other service each nearby.

The policy for out of hours medical cover did not state the time it would be expected for a doctor to attend the hospital in an emergency. It stated that the doctor on call would be expected to call back within 20 minutes and that the medical director would approve whether the doctor was located close enough to the hospital. This was a previous provider's policy and was not in line with national guidance on doctors being able to attend psychiatric emergencies promptly.

## Mandatory training

Staff had received and were up to date with appropriate mandatory training.

Overall, staff in this service had undertaken 94% of the various elements of training that the hospital had set as mandatory.

## Mandatory training element

### Percentage of staff compliant (%)

Conflict Management - 99

Emergency first aid - 96

Safeguarding - 100

Health and safety - 91

Moving and handling - 99

Fire safety - 94

Infection control - 100

Medication Management - 94

Data protection - 98

Mental Capacity and Deprivation of liberty - 90

# Wards for people with learning disabilities or autism

Food Safety - 97

Equality and diversity - 97

Mental Health Act - 100

Care certificate - 81

Staff had administered rapid tranquilisation three times in the 12 months leading up to the inspection. The Resuscitation Council UK Quality standards for cardiopulmonary resuscitation practice and training state that if staff undertake rapid tranquilisation they should be trained to intermediate life support standard. None of the staff at the hospital had had this training. Staff on the unit were only trained in emergency first aid; which was the equivalent of basic life support.

## Assessing and managing risk to patients and staff

### Assessment of patient risk

The inspection team looked at six care records and they all demonstrated good practice in risk assessment.

Staff did a risk assessment of every patient on admission and updated it at least monthly in line with the providers policy. Following incidents, the service completed a multidisciplinary team discussion and updated the risk management plan. However, there were a small number of occasions where risk assessments and management plans were not immediately updated following incidents.

Staff used an internal risk assessment tool which had developed by the provider specifically for the needs of their service user group.

### Management of patient risk

Staff were aware of and dealt with any specific risk issues, such as falls or food and fluid intake. We saw a patient that required food and fluid monitoring had food and fluid chart in place, but it lacked sufficient detail and follow up action. We informed the provider and they immediately rectified the situation, putting in place new guidance for staff.

Staff identified and responded to changing risks to, or posed by, patients.

Staff generally followed good policies and procedures for use of observation, including to minimise risk from potential ligature points. However, we found three patients were on bathing and showering observations because of

epilepsy but that these observations had not been adequately assessed on an individual basis or reviewed. We pointed this out to the provider and it was immediately reviewed and rectified.

We did not find any blanket restrictions on patients' freedom when we visited the hospital.

There was a large garden and grounds with designated smoking points that patients and staff could access. However, patients were offered access to smoking cessation support and advice if required.

## Use of restrictive interventions

There were no episodes of seclusion in the last year leading up to this inspection. There was one episode of long-term segregation during this period. The patient that was in long term segregation was regularly discussed with hospital staff, care coordinators and commissioners to check that care was still appropriate. A manager from a different service also reviewed the care arrangements monthly to ensure they were still appropriate.

There were 1348 episodes of restraint, of which 755 of these were floor-based holds and 593 were none-floor based holds or other interventions. Fifteen different patients were restrained during this period of time.

The provider told us that the hospital did not train for this use of prone restraint and there was no recorded use of it.

The hospital participated in a number of restrictive interventions reduction programmes, which included:

- Reducing restrictive practice posters and information for patients and staff.
- Individual service user documents detailing reducing restrictive practice plans and individual strategies to de-escalate and manage challenging behaviour.
- All staff completed positive behaviour support and reducing restrictive practices training.
- All staff completed positive behaviour support academy workbook.

These measures had not been effective. The number of uses of restraint was increasing at the hospital and remained high. We concluded that there were ineffective processes in place to ensure that staff minimised the use of restraint.



# Wards for people with learning disabilities or autism

The hospital had used rapid tranquilisation three times in the last year leading up to this inspection. On two occasions, with the same patient, we could not find evidence that the necessary physical observations following rapid tranquilisation had taken place. We raised this concern with the hospital and they confirmed that the observations had not been recorded, although they believed that they had been completed. They explained that they would take steps to ensure these observations were carried out in future.

## Safeguarding

All staff were trained in safeguarding and those that we spoke to knew how to make a safeguarding alert. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. However, we are aware that at the time of the inspection, there was an ongoing police investigation into alleged abuse of patients at the hospital. A large number of staff had been suspended, including the registered manager and the deputy manager.

Staff that we spoke to knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff we spoke with could speak confidently about identifying people at risk of harm and they were able to give us examples of where this would need to be escalated.

The hospital was assessed by the provider as not being suitable for children to visit. We were told that individual arrangements would be made in circumstances where it was appropriate for a patient to come into contact with a child, for example, a family member.

## Staff access to essential information

The patient records were all paper based files.

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it, although we found information difficult to find in the different patient files. When we asked where a piece of information was recorded there was sometimes a delay in finding it. We felt that this could make it difficult for a new member of staff, such as an agency member of staff, to learn how to support a patient or learn about their history where this was necessary.

There were several documents within the patient records that would provide a more succinct overview of care, for example a one-page positive behaviour support plan.

We asked several staff to talk through a care plan and how to support particular patients and they were able to do so in a good level of detail, including one agency member of staff.

## Medicines management

Staff followed good practice in medicines storage in line with national guidance. The clinic area was very clean and well organised.

We checked seven medication records and found a number of concerns relating to the administration of medications.

Staff were not following PRN ('when necessary') medication protocols, including physical observations for several patients. We spoke with staff about this issue and the protocols were reviewed and changed to remove the unnecessary observations.

The provider policy stated that there should be written PRN protocols for physical health and mental health medicines for each patient but several of these were missing. One was missing for lactulose for one patient, one was missing for salbutamol for another patient, one was missing for paracetamol and codeine for another patient and one other patient was missing a PRN protocol for paracetamol use.

## Track record on safety

The hospital reported that there were eight serious incidents in the last 12 months. However, we are aware that at the time of the inspection, there was an ongoing police investigation into alleged abuse of patients at the hospital. A large number of staff had been suspended, including the registered manager and the deputy manager.

## Reporting incidents and learning from when things go wrong

Staff that we spoke to knew what incidents to report and how to report them. Health care assistants would document incidents relating to patients in the patient's record and notify a nurse on duty. The nurse on duty would then update an electronic system so that the incident

# Wards for people with learning disabilities or autism

could be escalated to the appropriate person. Incidents were reviewed by the manager and if necessary a regional manager. The provider also had a national risk manager who reviewed incidents as required.

We checked a number of reported incidents and they were accurately reported according to the notes written in the patient records.

Staff that we spoke to understood the duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. There were regular team meetings and handovers between shifts where feedback from incidents would be discussed. The provider also held regional governance meetings where managers and staff from different sites had the opportunity to come together to discuss incidents.

There was evidence that changes had been made as a result of feedback. We were given examples of where changes to the environment were made as a result of incidents reported and reviewed. The layout and serving times in the kitchen were changed as a result of feedback to ensure that patients had adequate space and time to use the facilities properly. Also, as a result of one patient's condition and through feedback from staff that support them, changes were made to ensure this patient had separate access to the garden and outside space, ensuring his needs could be met.

Staff were debriefed and received support after a serious incident; staff said they felt well supported by their immediate colleagues and the management team in general.

## Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Inadequate 

### Assessment of needs and planning of care

We examined five care records and although we found some areas for improvement they demonstrated areas of good practice.

Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. Staff assessed patients' physical health needs in a timely manner after admission.

Staff developed detailed care plans that met the needs identified during assessment, there was clear correlation between documented assessment and care plans. However, we found care records to be complicated and cumbersome, it was hard to find some information that we were looking for. Although staff could assist and knew where to look for information, we felt that it could be difficult for a new member of staff to navigate the system. We spoke to the provider about this and they explained that they were in the process of reviewing the patient records, including the possible implementation of electronic patient records.

One patient's care plan specifically stated throughout it that they should only be supported by male staff. However, there was a female key worker listed on their core team and the care plan stated that on occasions a female member of staff could accompany a male member of staff to try to wake them up in the morning, as they responded well to this. We felt that this issue could lead to ambiguity for staff which could lead to the care plan not being followed. We pointed this out to staff and they took immediate action to ensure that the care plan matched the requirements detailed elsewhere in the patient care record.

Another patient had stated observation levels as two to one with either one male and one female staff or two female staff. However, the patient's communication passport stated that they prefer male staff to observe them. We felt these two documents contradicted each other, causing possible confusion for staff and the patient.

Care plans were personalised, holistic and recovery-oriented and they were updated when necessary as a result of progress made or as a result of multi-disciplinary team reviews. Positive behaviour support plans were written in a way that could help staff to identify triggers at the earliest opportunity and avoid the use of restraint. There were details of actions to take and strategies to use to de-escalate patient behaviour in the least restrictive way possible. These strategies were broken down into the different stages of patient behaviour, for example, primary and secondary strategies. It was

# Wards for people with learning disabilities or autism

therefore made clear for staff reading the plans which level of intervention was necessary at each different stage of behaviour. Despite this, staff used physical restraint very frequently and the reported use of restraint had increased.

## Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included access to medical treatment, psychological therapies, and other psychosocial interventions including daily living skills and group work where appropriate and an extensive range of activities onsite and within the local community.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. We saw evidence of GPs, dentists, opticians and hearing specialists all having visited the service to ensure that patients physical health was addressed.

Staff assessed patients' needs for food and drink and for specialist nutrition and hydration. However, we saw one example where a patient was supposed to be having their food and fluid intake assessed but this lacked detail and we could not see evidence that it had been discussed further. We spoke to the provider about this and they issued new guidance to staff on how to monitor and support patients in this area.

Staff were making efforts to support patients to live healthier lives. For example, there was a range of physical activities available and a sports activity co-ordinator came into the service once a week to carry out physical activity sessions. The garden was also equipped with lots of outdoor games that people could engage in if they wished.

During our visit, we carried out three 20-minute short observational framework for inspector observations, one specific observation of care being delivered and also observed other work being undertaken whilst we were carrying out other tasks such as touring the premises.

Despite the activities on offer the patients' records did not always show that patients had been fully encouraged to engage in meaningful activities. Some entries were more detailed than others. During observations we also saw a lot of patients watching TV or sat inactive with staff.

Staff used recognised rating scales to assess and record severity and outcomes including motivational and functional analysis, and these informed the care planning process.

## Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the ward. These included psychiatrists, clinical psychologists, speech and language therapists, activity coordinators, nurses and other physical and mental health specialists.

Staff employed by the service had received training in positive behaviour support (95% of staff), introduction to learning disabilities (100% of staff), autism (77% of staff) and personality disorder (83% of staff). Agency staff, who often made up to 50% of the staff on duty, had not completed any specialist training.

Managers provided new staff with appropriate induction and 81% of the staff that needed to had completed the Care Certificate. We saw examples of staff induction plans and evidence that tasks had been carried out and assessed to prove competence in specific areas.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers ensured that staff had access to monthly team meetings. We saw an example of team meeting notes and they appeared to follow a set agenda which included an opportunity for staff to discuss learning from incidents and sharing good practice.

The percentage of staff that received regular supervision was 81%.

The percentage of staff that had had an appraisal in the last 12 months was 82%.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff told us that if they highlighted a piece of training that they felt would be helpful to them, then provider would take a positive approach to providing it.

## Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings. These were held every week and were well attended; patients were discussed on a four-week cycle and more

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often if necessary. All staff spoke positively of the multidisciplinary approach to work that the hospital took. Psychiatrists, psychologists, activity co-ordinators, speech and language therapists for example were involved where necessary and patients were also encouraged to attend and, on some occasions, did so.

Staff shared information about patients at effective handover meetings within the team between each shift. This involved staff from the outgoing shift with staff that were coming on duty. They discussed incidents that were current or that might still be ongoing. They were also used to pass on messages to staff in relation to the outcome of previous incidents, for example learning that needed to be disseminated.

The hospital had effective working relationships with teams outside the organisation for example local physical health care providers. This enabled staff to provide the necessary physical healthcare for the patients that found it difficult to access external services such as these. They worked alongside specialist staff, for example, speech and language therapists and a functional specialist nurse to ensure that patients' needs were effectively met.

## Adherence to the MHA and the MHA Code of Practice

All staff had received training in the Mental Health Act.

Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and the hospital had access to a named Mental Health Act lead.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy services. The provider had a contract with a local provider and they came into the service once a week to meet with patients. There were posters up around the hospital and in easy read format; they explained that advocacy services could also be contacted by phone if required.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated as required and recorded that they had done so. This was done in line with the provider policy and the Mental Health Act.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Patients and staff were able to have a copy of these forms where it was necessary. Examples of leave granted that we looked at were for a variety of activities including attending appointments, social activities and visits with families and carers.

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

Staff stored copies of patients' detention papers and associated records correctly so that they were available to all staff that needed access to them. The service had separate paper files for each patients' Mental Health Act paperwork and they were organised and easy to navigate.

There were no informal patients staying at the hospital when we visited.

## Good practice in applying the MCA

Ninety percent of staff had had training in the Mental Capacity Act.

There were no deprivation of liberty safeguards applications made in the last 12 months at this hospital.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it and knew where to get advice from if they needed it.

Whilst staff assessed patients' capacity where this was appropriate and documented this, however, we did not see evidence that these were carried out on a decision specific basis. Instead, over-arching capacity assessments were carried out with patients which covered a number of different areas. Two of the seven patient bedrooms were completely bare apart from a bed. During the inspection, staff were unable to provide evidence as to why this was the case. Evidence submitted after the inspection did not provide adequate information to indicate that the rooms were bare due patients' sensitivities. Some information provided referenced patient sensitivities but no there was no

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evidence that this had been regularly reviewed or assessed. In addition, there were no decision specific capacity assessments or best interests decisions documented about these particular aspects of care.

When patients lacked capacity, staff made decisions in their best interests. However, a number of the best interest documents contained generic statements about a patient's diagnosis, for example, the patient is autistic. From the evidence we saw there was also a lack of patient, family, carer or advocate involvement in the best interest decision making process.

We saw an example of a Mental Capacity Act audit that had been carried out the previous year. This audit stated the hospital was 94% compliant in this area. However, it highlighted a number of capacity assessments that had not been reviewed.

## Are wards for people with learning disabilities or autism caring?

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

At the time of the inspection, there was an ongoing police investigation into alleged abuse of patients at the hospital. A large number of staff had been suspended, including the registered manager and the deputy manager.

We did not speak to patients when we carried out this visit, we were therefore not able to ascertain if patients felt staff treated them well or behaved appropriately towards them or not. However, during our visit we carried out a number of observations and saw staff treating patients with kindness and behaving appropriately towards them. These interactions were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.

We saw examples of patient involvement in multidisciplinary team meetings where their care was discussed and where potential changes to their care plan would be made. Staff working in the service were approachable and had the time to be able to respond to a patient where necessary.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, we saw evidence of patients being offered

appropriate physical health care appointments and where they were not able to attend external appointments we saw evidence of arrangements put in place for patients to be seen at the hospital.

Staff understood the individual needs of the patients, including their personal, cultural, social and religious needs. We asked a number of staff to talk to us about the care and treatment they were expected to deliver to patients and they were able to talk in detail about how to support patients and this detail correlated to care records that we examined.

Staff generally maintained the confidentiality of information about patients. However, we did see an example of a patients detailed forensic history stored in a paper file that all staff had access to. We pointed this out to the provider and they immediately took action to review the storage of such sensitive information.

### **Involvement in care**

#### **Involvement of patients**

Staff used the admission process to inform and orient patients to the ward and to the service.

It was clear that staff involved patients in care planning and risk assessment as the care plans reflecting the specific needs of each patient. There were a number of documents contained within care records that were written in a format that patients with a learning disability for example would be able to understand. Patients could access their own care records if they wished.

We observed staff communicating with patients so that they understood their care and treatment. Patients had communication passports in place and where specific needs were highlighted it was clear in the care plans. However, we found that one patient was assessed as requiring the use of Makaton and visual aids to help them communicate but during our observations we did not see staff using these methods. We asked a member of staff if they could explain why they were not being used and they told us that the patient could respond to verbal questions to communicate their needs but that visual aids would be present in their bedroom and lounge to help them make choices about activities and to structure their day. We checked this area and again they were not being used. We pointed this out to staff on the duty who said they would address this concern.

# Wards for people with learning disabilities or autism

We saw easy to read posters on the walls encouraging patients to give feedback. We were shown photographs of community meetings taking place. These meetings involved patients in decisions about the hospital, these were held on a regular basis, at least monthly, sometimes more often. They were conducted using white boards with pictures and easy to read language. We also saw evidence of a people's parliament that the provider held in the region; patients were able to attend to represent theirs' and the other patients' opinions.

There were posters promoting a local advocacy service which included a telephone number. The provider had an arrangement in place for the local advocacy provider to come into the hospital one day per week, usually on the day that the multi-disciplinary meetings took place.

## Involvement of families and carers

At the time of the inspection, there was an ongoing police investigation into alleged abuse of patients at the hospital. A large number of staff had been suspended, including the registered manager and the deputy manager.

Staff told us that they informed and involved families and carers appropriately and provided them with support when needed. We did not speak to any family members or carers during this visit, so we were not able to confirm if they felt sufficiently involved in their relative's care. We did however see examples of patient newsletters which we were told were used to support patients to keep in touch with families and carers and inform them of their progress. The newsletters contained statements from patients about activities they had been involved in and pictures of patients taking part in various different activities.

The hospital had a designated family visit room which they used when patients wanted to speak privately with a family member during a visit.

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

(for example, to feedback?)

## Access and discharge

### Bed management

The hospital had admitted 13 patients in the last year whose home address was in a different part of the country.

Staff told us that if a patient required more intensive care then they would liaise with the patient's commissioners and care coordinators and do everything necessary to facilitate a transfer, for example, arranging assessments or visits to more appropriate services.

## Discharge and transfers of care

In the last 12 months, there were four delayed discharges from this hospital. The reasons for delayed discharge were related suitable alternatives being found and issues with the mental health act status of the patient.

Staff planned for patients' discharge, including good liaison with care managers/co-ordinators.

Staff supported patients during referrals and transfers between services. They planned discharge well and liaised with other relevant professionals to enable effective discharge.

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

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. All bedrooms had their own ensuite bathroom. Some bedrooms also had private lounges which gave patients who required it additional living space.

Patients could personalise bedrooms and a number of the bedrooms we saw had been personalised. Two of the seven patient bedrooms were completely bare apart from a bed. During the inspection, staff were unable to provide evidence as to why this was the case. Evidence submitted after the inspection did not provide adequate information to indicate that the rooms were bare due patients' sensitivities. Some information provided referenced patient sensitivities but no there was no evidence that this had been regularly reviewed or assessed. In addition, there were no decision specific capacity assessments or best interests decisions documented about these particular aspects of care.

Patients had somewhere secure to store their possessions. All patients had lockable cupboards and wardrobes; some

# Wards for people with learning disabilities or autism

patients had unlimited access to these but others would need to be accompanied by a member of staff. Where it was necessary individualised plans were in place to manage access to patients belonging.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. There was a well-equipped hub within the hospital where patients could access a range of social and educational activities, computers, a sensory room and therapy rooms. The hub also contained a small kitchen area that enabled staff to facilitate daily living skills sessions where this was necessary. There was a large garden which was well kept and included a shed that contained bikes and other outdoor equipment that could be used by patients.

There were quiet areas in the hospital and a room where patients could meet visitors. The hospital had a number of different lounges, one for female patients only.

Patients could make a phone call in private if they were able to do so.

The food was of a good quality; the hospital had a well-equipped kitchen, servery and dining room. The hospital had dedicated kitchen staff but patients that wanted to and were able had the option of shopping and cooking for themselves in a separate kitchen. Patients could make hot drinks and snacks 24/7 and where necessary staff were always available to assist them with this if required.

Patients had access to a range of activities either at the hospital or in the local community, including:

- Computer access.
- Arts and crafts.
- Musical instruments.
- Movie nights.
- On-site sensory room.
- Walking and back-packing.

## Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. Staff told us that several patients had started formal learning activities whilst staying at the hospital. We also saw evidence that the hospital facilitated sessions in literacy and numeracy skills and essential daily living skills.

Staff told us about work they had done to encourage patients to keep in contact with families, for example regular patient newsletters that were put together and distributed. Contact details for families and carers were easily accessible for patients and staff, should they be required.

We saw evidence of patients engaging with the local community, with one patient making use of the village hall to cook their meals and getting involved in some community events. We also observed several patients spending time with each other and it was clear that they had developed friendships with each other, this appeared to be encouraged by staff.

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

The hospital would be able to make adjustments for patients with a physical disability if they needed to. They had a range of rooms available at ground level including a lounge, a bathroom, meeting rooms and outdoor space. The hospital also had a lift which gave easy access to other floors, ensuring access for those that found using the stairs difficult. The hospital had access to a range of experts that would be able to advise staff how to ensure they met the needs of patients that required additional support in these areas.

Staff assessed the communication needs of patients and put appropriate plans in place which was documented on a communication passport. A number of staff were able to demonstrate their ability to use Makaton. However, we found that one patient was assessed as requiring the use of Makaton and visual aids to help them communicate but during our observations we did not see staff using these methods. The hospital displayed some easy read posters and made leaflets available for people that required them. There were also pictorial cards in use in different areas of the hospital, for example in the dining room which were making it easier for some patients to make choices about what to eat.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain for example. There was a good range of information available about different services that people could access.

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

# Wards for people with learning disabilities or autism

visited there were no patients that had a specific dietary requirements of this nature but the hospital had a well-equipped kitchen and offered a range of different meals at meal times which allowed patients a good choice.

## Listening to and learning from concerns and complaints

At the time of the inspection, there was an ongoing police investigation into alleged abuse of patients at the hospital. A large number of staff had been suspended, including the registered manager and the deputy manager

There were leaflets around the hospital and patients had access to advocacy to help them raise concerns should it be required.

We saw an example of a complaint a patient made that was investigated properly and where the hospital encouraged the patient to involve an advocate. The patient received feedback about the outcome of the complaint, this was given verbally to the patient and recorded in the outcome of the complaint.

We saw a number of examples of how complaints were dealt with and resolved. We saw evidence of analysis of outcomes and what lessons could be learnt from them. For example, a member of staff complained about how they were being supported by their line manager and a piece of work was conducted with those involved. A plan was put in place to ensure this member of staff felt adequately supported and the line manager offered advice on supporting staff.

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

Inadequate 

### Leadership

At the time of the inspection, there was an ongoing police investigation into alleged abuse of patients at the hospital. A large number of staff had been suspended. This included the registered manager and the deputy manager. Therefore, when we carried out this inspection, we were not able to make any judgement on their ability to lead or

manage the teams. However, there were a number of issues that we raised throughout our visit that we would have expected to have been addressed by an effective management team.

During our visit we met a number of senior managers and managers from other services that the provider managed. They could explain how the teams were working to provide care for patients. They demonstrated a good understanding how care was delivered to patients through care planning and risk management.

### Vision and strategy

The hospital had been taken over by the new provider in August 2018. We spoke to staff about the vision and values of the new provider and they were able to talk about what they were, even though they were relatively new. Staff were able to explain how the organisation's vision and values related to patient care.

Staff told us that there had been several visits, sessions and activities arranged by the new provider to enable them to learn about the new provider and how they operated. Staff were completing new training modules that the company had provided which would bring staff up to speed with the providers current policies, practices and procedures.

### Culture

We were shown the results of a staff survey that was conducted this year. Sixty-three percent of staff working at the hospital took part in the survey.

Staff that we spoke with said that they felt respected, supported and valued. They told us that they felt positive about working for the provider and for working in their particular team. The results of the staff survey suggested that staff felt valued and respected by their managers.

Staff told us that they knew how to use the whistle-blowing process and they also told us that the provider had a designated person that they could raise concerns with if they felt this was necessary.

Staff told us that they thought managers treated them fairly, but that issues and concerns were dealt with if it was necessary. Staff explained that there could be differences of opinion between groups of staff working on different shifts for example, but staff had the opportunity to speak about these types of things during team meetings and daily handover meetings.



# Wards for people with learning disabilities or autism

Staff told us that appraisals included conversations about career development and how it could be supported. Staff also said that there were opportunities for career progression within the hospital and the wider provider.

The hospital's staff sickness and absence were low in comparison to similar types of services.

Staff had access to support for their own physical and emotional health needs through an external provider that staff could contact whenever they wanted. Staff also received support from other professionals that worked at the hospital and the wider provider, such as psychologists.

## Governance

Due to the number of overall concerns identified, we concluded that effective governance systems were not in place to ensure that all policies and procedures were adhered to by staff working at the hospital. It was not clear from our findings that systems and measures put in place to improve some areas of practice were being maintained and kept up to date to ensure effectiveness. For example, there were a number of concerns relating to medication administration and monitoring found throughout our visit and there was an issue with access to agency worker staff profiles when we first arrived. There were also concerns about capacity assessments, communication needs not being met and a number of discrepancies found within care plans. Also, the measures put in place to reduce restrictive practices had not been effective. The number of uses of restraint was increasing at the hospital and remained high. We concluded that there were ineffective processes in place to ensure that staff minimised the use of restraint.

Recruitment procedures established to ensure staff employed in the service were of good character or had the necessary qualifications, competence, skills and experience required to carry out their role were not operated effectively. There were 70 staff employed at the time of our inspection; we reviewed 22 staff records and six of those related to staff members who had been suspended following allegations of abuse.

In the 22 staff records we reviewed, all had omissions in the records, including job descriptions, confirmation of successful completion of probationary period, photographic and proof of identification, a curriculum vitae, full employment histories, evidence of relevant qualifications required for the role, evidence of good

character, evidence of current disclosure and barring checks, identification of any relevant health problems, and interview questions and records for the job applied for. Missing information in the staff records reviewed also included completed induction checklists, mandatory training, and evidence of one to one meetings, supervision and appraisals.

There were daily handover meetings and regular team meetings where discussion about learning took place. Staff also received some feedback via email about incidents that they had been involved in, where this was necessary. Agency staff told us that they also attended team meetings on a regular basis as and when they were held.

Staff undertook or participated in local clinical audits, for example we saw an example of a review of all Mental Capacity Act paperwork which looked at specific cases and overall effectiveness. However, these audits were not sufficiently robust to identify the concerns we raised.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

## Management of risk, issues and performance

At the time of the inspection, there was an ongoing police investigation into alleged abuse of patients at the hospital. A large number of staff had been suspended, including the registered manager and the deputy manager.

There was a system in place to report and escalate risks and issues. We saw a database that showed which level a risk had been raised to and staff explained how this system was governed both locally by staff at the hospital and centrally by the provider. Staff at ward level could escalate concerns when required. They did this by speaking to their nurse on duty or by raising concerns with their manager in supervision.

However, there was not a system in place to ensure that daily environmental risk checks were being carried out, this meant that gaps in these checks went unnoticed by the provider.

The service had a detailed business continuity management plan. Which covered situations that could arise from adverse weather or flu epidemic, for example.

## Information management

# Wards for people with learning disabilities or autism

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

On a number of occasions during our visit we could not find information that we were looking for in the patient records. There were a number of different files for each patient which meant you had to know the system well to be able to find everything. We explained to staff that we felt the patient record was cumbersome and complicated and that new staff to the hospital might not be able to find everything they needed as easily as necessary. Staff explained that there was a plan to transfer some of the paper records onto an electronic system. There was not specific plan in relation to this but we were told it was imminent.

We also found a detailed forensic history contained within one patient record, which was easily accessible to all staff. We pointed this out to staff and asked if it was necessary to be stored in that way. Once we did this the file was reviewed and this piece of documentation removed, all other patient records were checked, and staff found no further such examples.

Team managers had access to information to support them with their management role. However, the system in place to allow the management team to effectively allocate agency staff on duty was poorly maintained when we visited. We felt that this issue could make it difficult for staff to ensure adequate staff allocation to ensure safe patient care. We asked the provider to respond to our concerns regarding this system and they did so immediately, putting in place a system that allowed easy access to this information. We tested the system once it was rectified and it was able to provide the necessary information required for staff to plan the shifts.

Staff made notifications to external bodies as needed, for example to local safeguarding teams.

## Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. For example, there were posters about the new provider and staff told us that they had been well informed about the transition to the new provider via sessions and visits to the hospital and via email.

There were regular patient meetings held at the hospital and these were conducted using different communication methods, for example pictures and basic text on a white board. Staff gave us examples of changes that were made as a result of feedback from these meetings such as purchasing of new equipment and choices of food at meal times.

Staff showed us examples of newsletters that were used to communicate updates and progress to families and carers.

Patients could attend a people's parliament which was held on a regular basis. Staff also said that the hospital received regular visits from the providers senior leadership team and that they occasionally attended local team meetings

## Learning, continuous improvement and innovation

We saw evidence that staff were taking part in peer supervision and clinical supervision and they told us that this led to useful discussion about improvements in practice but we did not see any specific examples of such improvements.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that systems and processes are established and operated effectively are in place to assess, monitor and improve the quality and safety of the service.
- The provider must ensure that care and treatment is provided with the consent of the relevant person, if the person lacks capacity then this must be done in accordance with the Mental Capacity Act and Code of Practice.
- The provider must ensure that people's individual care records, including clinical data and analysis, is written and managed in a way that keeps people safe.
- The provider must ensure that people can access information about skills, qualifications and suitability of staff to carry out their roles. This system must also take into consideration agency staff.
- The provider must ensure that staff using restraint or rapid tranquilisation receive training in immediate life support as a minimum standard as recommended by the Resuscitation Council (UK).
- The provider must ensure that effective processes are in place to ensure that staff minimise the use of restraint.
- The provider must ensure that patients' observations, including when showering and bathing, are adequately assessed on an individual basis and reviewed to ensure patients' privacy and dignity.
- The provider must ensure that all staff follow all policies in relation to medication.
- The provider must ensure that the necessary physical health checks following rapid tranquilisation are routinely carried out and documented.

- The provider must ensure that PRN protocols are written and implemented in line with provider and national guidance and that they are reviewed on a regular basis.
- The provider must ensure that staff provide person centred care which meets each patient's needs, in particular those patients with assessed communication difficulties and preferences around support from staff of a specific gender.
- The provider must ensure that staff safeguard confidential patient information appropriately.
- The provider must ensure that daily environmental risk checks are carried out.
- The provider must ensure that staff records are accurate, thorough and complete and that recruitment procedures are established and operating effectively to ensure that staff employed in the service are of good character, with the necessary qualifications, competence, skills and experience required to carry out their roles.

### Action the provider **SHOULD** take to improve

- The provider should take steps to reduce the use of agency staff.
- The provider should take steps to simplify the patient care record.
- The provider should ensure that staff deliver care and treatment to a good standard, as it is described in patient care plans.
- The provider should ensure that food and fluid intake is monitored effectively and that this leads to regular reviews of care and treatment.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care <b>How the regulation was not being met:</b>  Care and treatment was not always provided with the consent of the relevant person and in accordance with the Mental Capacity Act and Code of Practice.  Staff were not delivering person centred care which met the needs of each patient, particularly for patients with communication difficulties and preferences around support from staff of a specific gender.  <b>This was a breach of regulation 9</b>

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect <b>How the regulation was not being met:</b>  Patients' privacy and dignity was not always ensured.  Three patients were on bathing and showering observations because of epilepsy but these observations had not been adequately assessed on an individual basis or reviewed.  Staff did not safeguard confidential patient information appropriately.

This section is primarily information for the provider

## Enforcement actions

**This was a breach of regulation 10 (1)**

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

Regulation 12 CQC (Registration) Regulations 2009  
Statement of purpose

**How the regulation was not being met:**

Care and treatment was not provided in a safe way for services users.

Staff providing care and treatment to service users did not have the qualifications to do so safely; staff using restraint or rapid tranquilisation had not received training in immediate life support as a minimum standard as recommended by the Resuscitation Council (UK).

Medicines were not always managed properly and safely. The necessary physical health checks following rapid tranquilisation were not routinely carried out and documented, T3 consent to treatment forms were not accurate in relation to a patient's medication or a patient's capacity to consent to their treatment and understanding of their medication, and PRN protocols were not written and implemented in line with provider and national guidance.

Daily environmental risk checks were not being completed.

**This was a breach of regulation 12 (1)**

### Regulated activity

### Regulation

## Enforcement actions

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

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

### **How the regulation was not being met:**

Systems and processes were not established and operated effectively to assess, monitor and improve the quality and safety of the service or to assess, monitor and mitigate the risks relating to the health, safety and welfare of the services user, including systems and processes in place to monitor or review care plans and staff implementation of these.

Effective systems were not in place to monitor agency staff experience, skills and training or to ensure information could be accessed when required about all staff skills, qualifications and their suitability to carry out their roles.

Processes in place to ensure that staff minimised the use of restraint were not effective; the number of uses of restraint was increasing at the hospital and remained high.

Individual care records were not always maintained securely, accurate, complete, and contemporaneous, and written in a way to keep people safe. This included the recording of patient observations following rapid tranquilisation and safeguarding a patient's confidential information from all staff.

There were a number of different case files for each of the patients. This made it difficult for staff, and in particular new staff, to find specific items of information. In a service with high staff turnover that frequently employed agency staff, this potentially posed a risk to the quality and safety of patient care.

**This was a breach of regulation 17 (1)**

This section is primarily information for the provider

## Enforcement actions

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

#### **How the regulation was not being met:**

Recruitment procedures were not established or operating effectively to ensure staff employed in the service were of good character or had the necessary qualifications, competence, skills and experience required to carry out their role.

In the 22 staff records reviewed, six staff members had been suspended following allegations of abuse.

Recruitment procedures were not effective as there were omissions in the 22 staff records we reviewed, including job descriptions, photographic identification, full employment history details, references, curriculum vitae, evidence of disclosure and barring checks, evidence of completed training, induction, supervision and appraisals.

**This was a breach of regulation 19 (1) (2) (3)**