# Jeesal Cawston Park

## Quality Report

Jeesal Cawston Park Hospital,
Alysham road,
Cawston,
Norwich,
Norfolk,
NR10 4JD.
Tel: 01603 876000
Website: www.jeesal.org

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

## Ratings

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

### 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.

# Summary of findings

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

## Overall summary

We rated Jeesal Cawston Park as requires improvement because:

- Throughout the hospital, there were areas that needed some repair and had become dirty. The clinic room in the Manor had marks on the wall by the examination couch and dirty waste pipes by the sink. This could cause an infection control issue. Some patient bedrooms smelt of urine and had damp areas in the bathroom. Staff reported concerns that the hospital was not always clean and areas were in need of repair. Some family members said the hospital areas and patient bedrooms were dirty. These areas of concern had not been addressed by the hospital's cleaning staff or the dedicated maintenance team.
- On the Lodge, bedroom doors were untreated, scratched and scuffed. This could cause potential infection control issues. The providers' infection control audit (dated November 2016) had identified this. However, no action had been taken to address the findings of this audit.
- Staff rotas showed staff worked for long periods of a time without taking a break. We saw that these staff had requested to take their breaks at the end of the day to leave early. This meant there was not the correct level of staff on shift toward the end of that day.
- We reviewed 22 patient positive behaviour support plans and could not easily identify the assessments which helped staff to create them. Most of these did not have any indication as to the frequency, duration and severity of distressing behaviours, which was something that could have helped staff and patients monitor change.
- Physical health checks and physical health care entries were difficult to find on the provider's electronic system. There was a lack of consistency between where in the records, and when, staff recorded any medical or physical care concerns.
- The hospital did not use a recognised early warning system to monitor any deterioration in patient's physical health care if needed.

However:

- The person centred care guiding council group met weekly to discuss and improve person centred care across the hospital. Some outcomes of these meetings included findings from shadowing, a reduction in restrictive practices and developing MDT meetings to be more patient-centred. This group also aimed to have family representatives take part.
- Patient activities were rarely cancelled due to short staffing, activities, section 17 leave were planned, and staffing levels made to meet the requirements. Where activities had been cancelled, alternative options were in place.
- Meeting minutes showed managers had made changes following incidents. For example, changes were made to the environment of a patient's living area, to help prevent injury.
- The hospital had employed a transitional nurse who provided examples of how they supported admissions and discharges in a co-ordinated manner.
- Patients personalised their bedrooms, patients said they felt their rooms were big enough. We saw patients had personal possessions in their room.
- Staff knew patients' individual needs, background and had a good understanding of their mental health, physical health and learning needs. Staff shared examples of how patients had progressed since being at the hospital
- Staff involved patients and their family in assessments and care plans. Family members were invited to attend multidisciplinary meetings and reviews.
- Seven family members said they had seen a vast improvement in their loved ones since their admission to this service. They said they felt their loved one was safe, had demonstrated improved behaviours and was happy there.

# Summary of findings

## Contents

Requires improvement

# Jeesal Cawston park Hospital.

**Services we looked at**
Wards for people with learning disabilities or autism

# Summary of this inspection

## Background to Jeesal Cawston Park

Jeesal Cawston Park provides a broad range of assessment, treatment and rehabilitation services for adults with learning disabilities or autistic spectrum disorder. The patients receiving care and treatment in this service have complex needs, associated with mental health problems and may present with behaviours that can challenge.

The service is registered with CQC for the assessment or medical treatment for persons detained under the Mental Health Act 1983 and the treatment of disease, disorder, or injury.

There are 54 registered beds

As part of our inspection we inspected all six units:

- The Grange - a 15 bedded locked ward accepting both female and male patients.
- The Lodge - a 11 bedded locked ward accepting both female and male patients.
- The Manor - a 15 bedded ward which accepts both female and male patients.
- The Manor Lodge – has three self-contained flats where patients are supported to live independently
- The Manor Flats - has five individual living flats where patients are supported to live independently.
- The Yew Lodge - has two self-contained flats, where patients are supported to live independently.

There was a registered manager and a controlled drugs accountable officer in place.

There were 47 patients when we inspected. Three were informal, two were subject to Deprivation of Liberty Safeguards (where a person's freedom is restricted in their own interests to ensure they receive essential care and treatment), and 42 were detained under a section of the Mental Health Act.

The Care Quality Commission had carried out an unannounced inspection on 10 January 2017. The inspection was in response to concerns identified by a member of the public. This inspection focused on three domains, safe, effective and caring within two ward areas. This report identified concerns around the recording and delivery of safe care to some patients.

The last full comprehensive inspection took place on 22 – 23 September 2015. The service was rated as good.

## Our inspection team

Team leader: Lynda Day

The team that inspected the service included two CQC inspectors, an inspection manager, the Commission's national professional advisor for learning disabilities and autism services and two specialist professional advisors who had current experience of working with people with learning disabilities and or autism.

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. This was an announced inspection.

## 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?

# Summary of this inspection

- Is it responsive to people's needs?
- Is it well-led?

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- met with 13 patients who were using the service
- interviewed the registered manager and managers or acting managers for each of the wards
- spoke with 21 other staff members; including doctors, nurses, occupational therapist, psychologists and social worker
- talked to nine parents and family members of patients
- met with an independent advocate
- attended and observed one multi-disciplinary meeting
- collected feedback from four patients using comment cards
- reviewed in detail 17 care and treatment records of patients
- examined 22 behaviour support plans
- carried out a specific check of the medication management on wards
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

- Most patients reported that they felt safe in the hospital. For example, one patient explained that they could tell staff if they were not feeling safe and managers would look into this.
- Patients said they liked nursing and care staff and knew who their key worker was. They all liked their doctors.
- Most patients told us that they were happy at the hospital; they felt they had progressed with getting better and had opportunities to progress with their treatment.
- They said the activities were good and they particularly enjoyed going for walks, bowling, learning art, woodwork and going shopping.
- Two patients reported to us that some staff were rude, did not listen and the ward could be cleaner. These concerns were reported to the relevant ward manager.
- Some patients did not want to be detained in the hospital.

# Summary of this inspection

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

We always ask the following five questions of services.

### Are services safe?

Requires improvement 

We rated safe as requires improvement for Jeesal Cawston Park because:

- Throughout the hospital, there were areas that needed some repair and had become dirty. For example, six toilet seats were missing from patient bath-rooms; we raised this with the provider. The clinic room in the Manor had marks on the wall by the examination couch and dirty waste pipes by the sink. This could cause an infection control issue. Some patient bedrooms smelt of urine and had damp areas in the bathroom. Staff reported concerns that the hospital was not always clean and areas were in need of repair. Some family members said the hospital areas and patient bedrooms were dirty. These areas of concern had not been addressed by the hospital's cleaning staff or the dedicated maintenance team.
- Clinic rooms were equipped with a couch, scales and blood pressure monitors. However, on Lodge ward, staff had not recently calibrated the wrist monitor and it had not been PAT tested (a test on electrical appliances to see if they are safe to use).
- On the Lodge, bedroom doors were untreated, scratched and scuffed. This could cause potential infection control issues. The providers' infection control audit (dated November 2016) had identified this. However, no action had been taken to address the findings of this audit.
- Staff rotas showed staff worked for long periods of a time without taking a break. We saw some staff had requested to take their breaks at the end of the day to leave early. This meant there was not the correct level of staff on shift toward the end of that day.

However:

- Staff identified ligature points across the site (places where patients intent on self-harm might tie something to strangle themselves), and mitigated these through environmental risk management plans and escorted patients who were assessed as high-risk if needed in these areas.
- Patient activities were rarely cancelled due to short staffing, activities, section 17 leave were planned, and staffing levels made to meet the requirements. Where activities had been cancelled, alternative options were in place.

# Summary of this inspection

- Meeting minutes showed managers had made changes following incidents. For example, changes were made to the environment of a patient's living area, to help prevent injury.

## Are services effective?

**Requires improvement**

We rated effective as requires improvement for Jeesal Cawston Park because:

- We reviewed 22 patient positive behaviour support plans and could not easily identify the assessments which helped staff to create them. Most of these did not have any indication as to the frequency, duration and severity of distressing behaviours, which is something that could have helped staff and patients measure change over time.
- Physical health checks and physical health care entries were difficult to find on the provider's electronic system. There was a lack of consistency between where in the records, and when, staff recorded any medical or physical care concerns.
- The hospital did not use a recognised early warning system to monitor any deterioration in patient's physical health care if needed.
- There was limited detail as to how staff could engage with patients on a daily basis to help develop key rehabilitative skills. Some family members we spoke with said they thought more skill-based interventions could be introduced.
- The hospital used an electronic record system for patient care records. However, some records were in paper form and were kept in different locations. This meant that staff found it difficult to locate some records at times.

However:

- Patient care records contained up to date, personalised, holistic recovery goals. We saw care plans included nutritional, physical and psychological treatment, alongside working on relationships and boundaries.
- The provider had introduced staff training in September 2015 around 'understanding patient experience in inpatient services'. Patient shadowing had been identified as useful for staff to observe patient experiences and direct interactions from a patient in a particular activity.
- Multidisciplinary meeting were held. These were attended by doctors, staff and the patient wherever possible. The GP had provided feedback for staff and the social worker gave input. Patient incidents and current care plans were discussed.

## Are services caring?

**Good**

We rated caring as good for Jeesal Cawston Park because:

# Summary of this inspection

- Staff knew patients' individual needs, background and had a good understanding of their mental health, physical health and learning needs. Staff spoke about patients with respect and warmth. Staff shared examples of how patients had progressed since being at the hospital
- Staff involved patients and their family in assessments and care plans. Family members were invited to attend multidisciplinary meetings and reviews. Parents we spoke with said staff sent them a copy of the notes if they wanted.
- Seven family members said they had seen a vast improvement in their loved ones since their admission to this service. They said they felt their loved one was safe, had demonstrated improved behaviours and was happy there.

## Are services responsive?

Good

We rated responsive as good for Jeesal Cawston Park because:

- Patients moved between wards as part of their treatment progression on clinical grounds. A patient might progress from living on a ward, then move to one of the flats on site.
- Discussions were taking place with local commissioners to reduce the number of delayed discharges from the service.
- The hospital had employed a transitional nurse who provided examples of how they supported admissions and discharges in a co-ordinated manner.
- Patients personalised their bedrooms, patients said they felt their rooms were big enough. We saw patients had personal possessions in their room, photographs, large televisions and sofas.
- There were information posters displayed for patients to see how they could make a complaint. Complaint forms were easily accessible, we saw staff supported patient's to complete forms. There were information posters and easy read documents explaining patient rights.

However:

- There were six delayed discharges between July and December 2016, two patients discharge was delayed due to the patient needing permissions form the Ministry of Justice. Two patients' waited for a social care package to be put in place and two patients needed a suitable residential placement.

## Are services well-led?

Good

We rated well led as good for Jeesal Cawston Park because:

# Summary of this inspection

- Managers completed clinical audits, such as incident records, patient treatment engagement and file checks. Managers completed records audits on other wards, which allowed for constructive feedback to staff they would not normally manage.
- Managers addressed poor performance promptly. Managers were using the appraisals as an opportunity to give staff development in areas they chose. Some staff had been promoted into senior positions.
- The hospital was participating in the quality network for inpatient learning disabilities services; this was a good-standards based quality network to facilitate good practice.
- The provider had 10 staff members who were trained in coaching other staff in the development of positive behaviour support plans for patients.
- The person centred care guiding council group met weekly to discuss and improve person centred care across the hospital. Some outcomes of these meetings included findings from shadowing, a reduction in restrictive practices and developing MDT meetings to be more patient-centred. This group also aimed to have family representatives take part.

# 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.

- Ninety eight percent of staff had completed annual mandatory training in the Mental Health Act.
- During interviews, staff demonstrated awareness of the Mental Health Act principles. Manages had sent staff questionnaires to test staff skills around the MHA.
- Staff had not kept copies of each patient's consent to treatment with their medical prescription charts; however we found these in with patient hospital passports.
- Staff read patients their rights under the Mental Health Act, on admission and routinely thereafter. Staff used easy read material to help patient's review these.
- A dedicated member of staff checked and scanned MHA papers onto the hospitals electronic system. Checks were completed to ensure paperwork was correct as soon as patients were admitted to hospital.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- 98% of staff had up to date training in the Mental Capacity Act.
- There were two Deprivation of Liberties Safeguard (DoLS) applications in the last six months; both patients were discharged before the assessment took place. One patient had been waiting for a DoLS application for over a year; this was delayed from the assessment team in the local authority. Managers had proactive systems to review the application process with the local authority.
- During staff interviews, staff could not explain the statutory principles within the MCA, or how this related to their roles. However, staff said each patient's capacity was discussed at every patient review meeting.
- Records of patient capacity to consent were not always clearly recorded in patient records. However, we were shown where each patient's capacity was recorded on the electronic system or in review meeting notes. Capacity assessments were decision specific. This supported patients to make a decision where possible. We saw easy read information about capacity decisions for patients.
- Patients had access to an Independent mental health Advocacy service (IMHA). Patients told us how they could access this service. Patients told us the names of some IMHA staff and understood they could help with capacity issues, rights and referrals.
- The Mental Capacity Act including DoLS, policy was reviewed and in date.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Wards for people with learning disabilities or autism | Requires improvement | Requires improvement | Good | Good | Good | Requires improvement |
| Overall | Requires improvement | Requires improvement | Good | Good | Good | Requires improvement |

Requires improvement

# Wards for people with learning disabilities or autism

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

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

Requires improvement

### Safe and clean environment

- The layout of Lodge ward allowed staff to observe all parts of the ward and garden. Some rooms were adapted for staff to view patients through a Perspex panel when they were in their lounge area. However, all of the other wards had blind spots where staff could not observe all parts of the ward to maintain patient safety. Staff managed these through regular observations and individual patient risk assessments.
- Staff identified ligature points across the site (places where patients intent on self-harm might tie something to strangle themselves), and mitigated these through environmental risk management plans and escorted patients who were assessed as high-risk if needed in these areas.
- Wards complied with the Department of Health's guidelines on mixed sex accommodation.
- Clinic rooms were equipped with a couch, scales and blood pressure monitors. However, on Lodge ward, staff had not recently calibrated the wrist monitor and it had not been PAT tested (a test on electrical appliances to see if they are safe to use). The clinic room in the Manor had marks on the wall by the examination couch and dirty waste pipes by the sink. This could cause an infection control issue. Medications and resuscitation equipment were available in case of emergency. Records showed staff carried out daily checks to ensure they were in date and would work properly if needed.
- One seclusion room was being used on the Lodge; the room allowed staff to clearly observe any patient using that room, there was a clock, internal temperature control and an intercom to allow for clear communication. The seclusion room had en-suite toilet facilities.
- Throughout the hospital, there were areas that needed some repair and had become dirty. For example, six toilet seats were missing from patient bath-rooms; we raised this with the provider who confirmed that this had been addressed during our inspection.
- Some patient bedrooms smelt of urine and had damp areas in the bathroom. Staff reported concerns that the hospital was not always clean and areas were in need of repair. Some family members said the hospital areas and patient bedrooms were dirty. Cleaning schedules were seen and dedicated cleaners were carrying out their duties. Monitoring arrangements for cleaning duties were not clear.
- The provider carried out monthly environmental audits to check conditions, appearance, maintenance and cleanliness. The recent audit identified all areas that needed repairing and cleaning. The hospital had a maintenance team carrying out these duties across the hospital. However these areas of concern had not been addressed by the maintenance team.
- Staff carried out infection control audits every three month. An external infection control nurse carried out yearly audits. The infection control policy was in date. We saw staff washing hands, however there were few posters displayed which help identify good hand-washing practices. On the Lodge, bedroom doors were untreated, scratched and scuffed. This could cause

potential infection control issues. The providers' infection control audit (dated November 2016) had identified this. However, no action had been taken to address the findings of this audit.
- Staff carried personal alarms or radios for safety. These were checked daily to ensure they were working. There was CCTV cameras installed on the Lodge, Yew lodge and Manor lodge, there was no signage informing patients they were being monitored by cameras.

**Safe staffing**

- The established level of qualified nursing staff was 15, with 15 in post. The established levels of health care assistants were 74 and 22 senior support workers.
- The hospital used bank or agency nursing staff to meet the required numbers of staff per shift. The hospital and commissioners had approved one member of staff per two patients during the day and three patients to one staff member at night, as a minimum. These staffing levels included senior staff nurses, staff nurses, senior support workers and support workers. Some patients received additional two to one support based on assessed need for enhanced observation levels.
- The provider used a safe staffing tool for assessing staffing levels based on the context of care tool for learning disability services.
- The hospital used regular staff from one agency; these staff were familiar with the hospital and patients.
- Managers established staffing numbers and grade requirements using an electronic duty rostering system. Ward managers assessed patient numbers and the levels of observation staff for each patient. This helped generate the required level of staffing. Where staff levels were short, managers booked agency staff and reviewed short term staff absences in the morning management meeting.
- A qualified nurse was present on all wards at all times, the Yew lodge and Manor lodge shared nursing staff.
- There were regular activities and escorted leave. Each patient had personalised activities planned in and one to one time with their key nurse
- Patient activities were rarely cancelled due to short staffing, activities, section 17 leave were planned, and staffing levels made to meet the requirements. Where activities had been cancelled, alternative options were in place.
- Staff rotas showed staff worked for long periods of a time without taking a break. We saw some staff had requested to take their breaks at the end of the day to leave early. This meant there was not the correct level of staff on shift toward the end of that day. The daily duty rota demonstrated this. Senior managers were informed of this practice and confirmed that this would be addressed immediately to ensure patients were kept safe.
- Staff were aware of whom to contact when seeking medical advice day or night. Staff said out of hours GP's attended quickly. There were two full time consultant psychiatrists and one full time speciality doctor.
- Training records inspected showed 83% of staff had completed mandatory training. This included, safeguarding, medication awareness, information governance, nutrition, effective communication, de-escalation and positive behaviour support plans. Figures showed 28% of staff had received 'Prevent' this is anti-radicalisation training. This was low due to this being a new training programme and all staff were booked in to complete this within the yearly target.

**Assessing and managing risk to patients and staff**

- There were 36 incidents of use of seclusion and one patient was segregated long-term, in the six months preceding this inspection. This was on the Lodge, patients were admitted to the Lodge at the beginning of their treatment pathway, so were often more unwell than the patients on other wards.
- There were 347 incidents of use of restraint on the Lodge, 238 incidents on the Manor, 66 on the Grange and 19 between Yew and Manor lodges. This was between June 2016 and November 2016. This figure included any form of touch or hands on from staff and safe holds. We saw where patients care planning had identified guiding the patient to a quiet area or supporting them to walk when they were feeling distressed.
- Managers reviewed the use of restraint across all wards, the frequency of restraints was analysed, and a graph showed the use of restraint had reduced over an eight month period. For example 22 on the Manor and 23 on the Grange for February 2017.
- Staff used distraction techniques and talked calmly to patients to help manage behaviours. Staff we spoke with understood which techniques usually worked with

individual patients. Staff said that restraint was always a last resort. We looked at patient restraint records and found that staff had recorded restraint holds when necessary.

- We reviewed seclusion records and saw staff followed guidelines and best practice. One patient was secluded during the night, we saw a doctor had attended in good time to review this seclusion
- There were 16 episodes of prone restraint on the Lodge, of those, seven episodes related to one patient, this patient had an agreed action plan around using prone restraint as a safer way to restrain this patient. One patient preferred to roll themselves over into the prone position. Staff were quick to turn patients into the supine position if clinically safe to do so.
- Care and treatment records for each patient were reviewed. These showed that staff had completed and updated detailed risk assessments. These were reviewed at the monthly multidisciplinary team meetings. This allowed clinical staff to measure outcomes based on the risk assessments. Records showed where managers had reviewed individual observation levels for patients, based on measured outcomes of behavioural change.
- Staff had started to use a new least restrictive practice decision making tool. Restrictive practices are when staff make someone do something they do not want to do or stop doing something for their immediate safety and the safety or others. We saw where staff identified areas of concern for a patient and why a restriction was needed. Recording all options of restriction, the negative effects to the patient and the possible benefits to the patient for each option. Staff chose the least restrictive option. For example, a patient was restricted from eating with other patients in the dining room for a short period of time, as this caused difficult behaviours and a threat of violence toward others. This restriction had been reviewed by the multidisciplinary team before being agreed. Each separate restrictive practice adhered to the Mental Health Act, Code of Practice (2015).
- Observation policies were in date. Managers planned and allocated staff for patient observations, this was set around patient timetable's and activities, we saw staff breaks had been accounted for whilst they were observing patients. However, if staff were on section 17 leave with patients they may be allocated a longer time period.
- Staff followed the National Institute for Health and Care Excellence when administering rapid tranquilisation. The provider's tranquilisation policy was updated during June 2016 and included guidance for the Royal Collage of Psychiatry.
- Ninety three per cent of staff had completed safeguarding training. Staff knew what should be reported under the safeguarding procedures. We saw records where staff had dealt with a potential safeguarding issue.
- A pharmacist attended the hospital once a week to carry out audits and ensure national Institute for Health and Care Excellence guidelines were being followed in managing medicines. Medicines were secured appropriately. Staff checked room and fridge temperatures to ensure medicines were kept as per manufacturing guidelines. Staff reported and logged any medication errors and pharmacy contacts were available.
- The hospital allowed families and children to visit patients. This is booked in advance so the social worker could carry out advanced checks and arrange a suitable visiting room.

**Track record on safety**

- In the last 12 months there were three serious incidents, which senior management had investigated to reduce the risk or reoccurrence.
- The serious incidents included patient absconding and an injury to a patient.
- Senior managers discussed incidents daily and implemented plans to reduce the risk of reoccurrence.

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

- Staff recognised and reported incidents using an electronic reporting system. We saw staff reported a range of incidents.
- Staff were open and transparent to patients when something went wrong, we saw an example of a letter given to a patient summarising what was done when something went wrong, which was in an easy read version.
- Senior managers discussed incidents and lessons learnt at their team meetings. One staff member said they got told about anything that affects the ward.

Requires improvement

# Wards for people with learning disabilities or autism

- Meeting minutes showed managers had made changes following incidents. For example, changes were made to the environment of a patient's living area, to help prevent injury.
- Managers and psychology offered staff support after any serious incidents.

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

(for example, treatment is effective)

Requires improvement

### Assessment of needs and planning of care

- We reviewed 17 care and treatment records, staff completed a comprehensive assessment of risk during a multidisciplinary team meeting within 72 hours of each patient's admission.
- Most patients had positive behavioural support plans (PBS) in place; we reviewed 22 of these and could not easily identify the assessments which assisted staff to produce these with patients. Most of these did not have any indication as to the frequency, duration and severity of distressing behaviours, which was something that could have helped staff and patients monitor progress
- All PBS plans were current, staff gave patients copies of these if they wanted. The PBS plan included distraction techniques, soothing ideas and ways patients and staff could manage behavioural distress. The multidisciplinary team held a monthly group to review the progress, quality and implementation of these.
- Staff completed an initial physical healthcare examinations and monthly thereafter. However, we were unable to find three patients physical healthcare monitoring records on paper or in electronic records.
- Staff had developed a system which helped patients to report how they were feeling and communicate to staff if they felt unwell. However, physical health checks and physical health care entries were difficult to find on the electronic system. There was a lack of consistency between where in the records, and when, staff recorded any medical or physical needs. For example, the doctor saw a patient in the morning and made an entry requiring the patient's fluid intake to be monitored, however there was no record of this being commenced or recorded in the patient's progress notes at 15.30.
- The hospital did not use a recognised physical healthcare early warning system to monitor any deterioration in patient's physical health care if needed.
- Some patient care records contained up to date, personalised and holistic recovery goals. These care plans included nutritional, physical and psychological treatment, alongside working on relationships and boundaries. However some care plans lacked detail as to how staff could engage with patients on a daily basis to help develop key rehabilitative skills. Some family members we spoke with said they thought more skill-based interventions could be introduced.
- The hospital used an electronic record system for patient care records. However, some records were in paper form and these were kept in different locations . This meant that staff found it difficult to locate some records at times.

### Best practice in treatment and care

- A range of psychological therapies recommended by the National Institute for Care and Excellence was available for patients. There was a learning disabilities psychologist and psychologists working with education and social needs on site. Interventions were adapted based of comprehensive assessments to meet the needs of the patient group. We saw one patient was encouraged to have more contact with other patients and staff, and this was being introduced gradually.
- A GP visited the hospital, and ran weekly clinic sessions for patient's physical healthcare needs. A physical healthcare nurse was also available. Patient had hospital and dental appointments when needed.
- Staff used recognised rating scales to assess and record outcomes. For example, the use of health of the nation outcome scales for patients with learning disabilities. However, these were stored in different parts of the electronic record for individual patients. This meant they could not be located easily by front line staff.
- The provider had introduced staff training in September 2015 around 'understanding patient experience in inpatient services'. Patient shadowing had been identified as useful for staff to observe patient experiences and direct interactions from a patient in a particular activity. Staff aimed to address patient needs on an individual basis after identifying how needs could

be met and with shared decision-making. We reviewed the provider's own action plan and found that they were at the stage of implementing the use of least restrictive practice decision making tools.

**Skilled staff to deliver care**

- There was a range of mental health disciplines, qualified nursing staff, trained support workers, psychiatrists, a speech and language therapist, occupational therapists and a social worker on site. This meant that patients had access to a variety of skilled staff to provide care and treatment.
- Staff had access to appropriate training and development. Records showed staff had completed training that was relevant to their role. Staff said they had opportunities to develop the skills they needed through training. For example autism awareness and developing positive behaviour support plans. The hospital had a training centre away from the hospital which allowed staff to be away from the site to learn more effectively.
- New staff received an induction; their performance was reviewed during their induction period and in supervision. New heath care workers completed the Care Certificate during their probationary period.

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

- There were multidisciplinary meetings twice a week. Managers discussed patient incidents, reviewed medication and staffing. Patients were supported to attend these meetings. One of these meetings was observed during the inspection and found to be of value to patients and staff.
- Each ward completed a handover at the start of each shift, managers and staff discussed any key issues identified that day and staff discussed each patient.
- Multidisciplinary meeting were held. These were attended by doctors, staff and the patient wherever possible. The GP had provided feedback for staff and the social worker gave input. Patient incidents and current care plans were discussed, this allowed senior MDT members to share professional advice and make informed decisions.
- We reviewed minutes of patient best interest decisions; these included the use of external best interest assessors and of other professionals.
- Records seen demonstrated that the hospital had good working relations with external professionals.

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

- The Mental Health Act Administrator carried out monthly audits of MHA papers to ensure detentions remained legal.
- Staff knew a Mental Health Act Administrator was available to offer support to staff. There was a quick reference guide for staff to refer to when checking paperwork.
- Since our last visit, staff had developed section 17 leave sheets, which recorded the leave granted, the length of leave and contingency measures. We saw staff had recorded clothing and details of patient's trips on the leave forms.
- Since our last visit, staff recorded details about the outcomes of patients section 17 leave either on the electronic system on the paper form.
- 98% of staff had completed annual mandatory training in the Mental Health Act.
- During interviews, staff demonstrated an awareness of the Mental Health Act principles. Manages had sent staff questionnaires to test staff skills around the MHA.
- Staff had not kept copies of each patient's consent to treatment with their medical prescription charts; however we found these in with patient hospital passports.
- Staff read patients their rights under the Mental Health Act, on admission and routinely thereafter. Staff used easy read material to help patient's review these.
- A dedicated member of staff checked and scanned MHA papers onto the hospitals electronic system. Checks were completed to ensure paperwork was correct as soon as patients were admitted to hospital.

**Good practice in applying the MCA**

- 98% of staff had up to date training in the Mental Capacity Act.
- There were two Deprivation of Liberties Safeguard (DoLS) applications in the last six months, both patients were discharged before the assessment took place. One patient had been waiting for a DoLS application for over a year, this was delayed from the assessment team in the local authority. Managers had proactive systems to review the application process with the local authority.
- During staff interviews, staff could not explain the statutory principles within the MCA, or how this related to their roles. However, staff said each patient's capacity was discussed at every patient review meeting.

Requires improvement

# Wards for people with learning disabilities or autism

- Patient capacity to consent was not always clearly recorded in patient records. However, we were shown where each patient's capacity was recorded on the electronic system or in review meeting notes. Capacity assessments were decision specific. This supported patients to make a decision where possible. We saw easy read information about capacity decisions for patients.
- Patients had access to an Independent Mental Health Advocacy service (IMHA). Patients told us how they could access this service. Patients told us the names of some IMHA staff and understood they could help with capacity issues, rights and referrals.
- The Mental Capacity Act including DoLS, policy was reviewed and in date.

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

Good

### Kindness, dignity, respect and support

- We observed staff interacting with patients in a positive and engaging way. Staff used good communication techniques to support patients and took time to explain tasks when needed.
- There was a positive and friendly atmosphere between staff and patients. Patients knew staff names and staff responded to patient's requests, such as painting their nails.
- Staff knew patients individual needs, background and had a good understanding of their mental health, physical health and learning needs. Staff spoke about patients with respect and warmth. Staff shared examples of how patients had progressed since being at the hospital
- We spoke with 13 patients. They reported they felt safe, one patient explained that they could tell staff if they were not feeling safe and managers would look into this.
- Most patients said they liked nursing staff and knew who their key worker was. They all liked their doctors. However, two patient reported that some staff were rude, did not listen and the ward could be cleaner. These individual concerns were raised with the relevant ward manager
- One patient reported that their medication made them feel tired and slurred their speech. We brought this to their responsible clinician's attention who reviewed this immediately.
- Patients felt they had progressed with getting better and had the opportunity to move on.

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

- Records seen showed us that staff supported patients upon admission by orientating them to the ward and the wider hospital site.
- Staff involved patients and their family in assessments and care plans. Family members were invited to attend multidisciplinary meetings and reviews. Parents we spoke with said staff sent them a copy of the notes if they wanted. Some patients did not have a copy of their care plan through choice. The provider was introducing an electronic system that patients could access through their television. This would provide patients with a visual guide to their own records
- Family members gave mixed views about their involvement in their relatives care. All family members regarded the doctors highly and felt doctors, psychologists and the social workers took time to explain to them details around medication and treatment. However, some carers reported they felt some staff just observed the patient and did not engage with them.
- Seven family members said they had seen a vast improvement in their loved ones since their admission to this service. They said they felt their loved one was safe, had demonstrated improved behaviours and was happy there.
- Patients had access to local independent mental health advocacy services. There were posters and photographs of these advocates, patients we spoke with knew their names and said they were visited often and when requested. We saw that different staff could refer a patient to this service.
- Patients gave feedback on their care and the service in ward based meetings. These were held weekly on The Lodge, the Grange and Manor. Patients from Yew and Manor lodge could provide feedback during a ward visit from management or to staff at any time. One patient we spoke with on Yew lodge said they had raised several views and felt staff listened.

Requires improvement

# Wards for people with learning disabilities or autism

- The provider completed a patient survey in 2016 to collect patient views. This covered patient satisfaction, choice and quality of life. The results showed patients felt safe on the wards and staff helped them as much as possible.
- However, the results also showed that patients wanted more activities, the food could improve and they wanted more information about the hospital before they were admitted.

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

(for example, to feedback?)

Good

### Access and discharge

- Average bed occupancy over the last six months was 90% with the average length of stay being 14 months. Bed occupancy was highest on Yew lodge being at 100%. On the Manor and the Grange patients could progress to a community discharge if possible.
- The hospital accepted patients from all parts of the country. If possible, patients were discharged to a suitable placement closer to home.
- Each patient had received an independent care and treatment review by NHS England. Plans were in place to support the outcome of these reviews for individual patients.
- Patients moved between wards as part of their treatment progression on clinical grounds. A patient might progress from living on a ward, then move to one of the flats on site.
- There were six delayed discharges between July and December 2016, two patients discharge was delayed due to the patient needing permissions form the Ministry of Justice. Two patients' waited for a social care package to be put in place and two patients needed a suitable residential placement.
- Discussions were taking place with commissioners to reduce the number of delayed discharges from the service.
- The hospital had employed a transitional nurse who provided examples of how they supported admissions and discharges in a co-ordinated manner.

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

- There was a full range of rooms available within the hospital. Patients from Yew and Manor lodges attended the activity centre, gym, art room and separate woodwork room if they wished to engage in activities.
- On the Manor, Grange and Lodge wards, there were quiet lounge areas for both male and female patients. There was a dedicated visitors' room off the wards
- Patients had access to a pay phone. Staff would give patients a portable phone if they wished to speak in their room. This was risk assessed.
- The hospital was set on several acres of gardens; patients were risk assessed before accessing these. On the Lodge, patients could access an enclosed garden with staff.
- A range of food was available at meal times, the hospital completed a patient survey where most patients said they liked the food or it was ok and most said they thought it was healthy.
- There were hot drinks and snacks available to patients throughout the day.
- Patients personalised their bedrooms, patients said they felt their rooms were big enough. We saw patients had personal possessions in their room. For example, photographs, large televisions and sofas.
- Three family members we spoke with had concerns around the amount of clothing patients seem to lose or damage in the wash. The provider confirmed that these concerns were being investigated.
- Patients had electronic keys to their rooms or a lockable cupboard. However, some patients said their possessions were kept in a store room. One family member was concerned as their son said some items were stored away and he did not know why or where they were put. These individual concerns was reported to senior managers
- Individual activity timetables showed that these were available at all times, including at weekends.

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

- Some bedrooms were adapted to support people with limited physical disability. However, there was no wheelchair access or accessible toilets. Senior managers informed us that patients with disabilities were assessed as to their suitability for admission to this service.

Requires improvement

# Wards for people with learning disabilities or autism

- Staff had forms and information leaflets in a variety of formats, including easy read and pictorial. Secure noticeboards were in place.
- The hospital provided a menu for patients to choose a variety of meals each day, this menu had healthy options available. Patients said they liked the food. Food choices for religious and cultural needs were catered for.
- Within the hospital patients could use a visiting room or quiet area as a multi-faith room. Staff took patients to a local church and provided information about faith when requested.

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

- There were information posters displayed for patients to see how they could make a complaint. Complaint forms were easily accessible; we saw staff supported patients to complete these. There were information posters and easy read documents explaining patient rights.
- The provider received 103 complaints in the last 12 months, 58 were upheld. No complaints were referred to the public health service ombudsman. The provider had investigated the complaints to learn lessons, and had apologised when required in line with the duty of candour.
- Staff gave patient's information about how to complain on admission. Staff offered and helped patient's complete complaint forms if appropriate.
- Patients said they knew how to complain, two patients said they felt staff may not listen, but said they had opportunity to tell a manager if they wanted.
- Managers discussed the outcome of complaints with patients and in staff meetings. We saw a letter that had been given to a patient outlining the outcome of a complaint, and this was also shared in a patient community meeting.
- Three parents said they had complained about the loss of clothing, they explained they had received an outcome letter from the provider. However, they felt this was still an ongoing issue.
- Seven compliments had been received in the last 12 months.

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

Good

**Vision and values**

- The provider's vision and values were on display throughout the service and on their welcome pack. Staff were given these as part of their induction.
- Staff knew these values, in interviews staff talked about the varied individual needs each patient had and how they cared for these.

**Good governance**

- An electronic system allowed senior staff to monitor compliance rates with mandatory training.
- Staff received supervision every two months, supervision covered topics such as patient cases, workload, development and training. Supervision records showed that staff were up to date on supervision. However, 14 staff were due to have supervision on Yew and Manor lodge in the next month.
- All staff had had an up to date appraisal in the last 12 months on the Manor and Grange. On the Lodge, Yew lodge and Manor lodge 80% of staff had had an appraisal. Managers had scheduled the remaining staff appraisals.
- We reviewed five staff files, all were completed fully and included job descriptions, recruitment documents, Disclosure and Barring Service Certificate checks and references.
- Managers completed clinical audits, such as incident records, patient treatment engagement and file checks. Managers completed records audits on other wards, which allowed for constructive feedback to staff they would not normally manage.
- Managers addressed poor performance promptly. Managers were using the appraisals as an opportunity to give staff development in areas they chose. Some staff had been promoted into senior positions.

**Leadership, morale and staff engagement**

- Sickness and absence rates over the last 12 months were set at an average of two percent.
- Staff were aware of the providers whistleblowing policy, staff felt able to report concerns without fear of victimisation.

Requires improvement

# Wards for people with learning disabilities or autism

- Staff said morale was generally good, that everyone enjoyed their job. Some staff reported that when they were short staffed and if they felt managers had not addressed this, this had an effect on morale.
- A staff survey revealed that staff requested social facilities and a comfortable room for staff breaks. The hospital had been carrying out some refurbishment and we saw some wards were being improved to facilitate this. 86 out of 168 staff reported that communication to staff from the company is poor, the provider has started to produce electronic staff records and information boards across the hospital. There was a focus group working on how this can be improved.

**Commitment to quality improvement and innovation**

- The hospital was participating in the Royal College of Psychiatrists quality network for inpatient learning disabilities services; this was a standards based quality network to facilitate good practice across similar services nationally.
- The provider had 10 staff members who were trained in supporting other staff in developing patient's Positive Behaviour Support Plans.
- The person centred care guiding council group met weekly to discuss and improve person centred care across the hospital. Some outcomes of these meetings included findings from shadowing, a reduction in restrictive practices and developing MDT meetings to be more person-centred. This group also aimed to have family representatives take part.
- The training department was awarded a Skills for Care award and endorsed as a Centre of Excellence in January 2017.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must provide a safe and clean environment.
- The provider must ensure that all clinic equipment is clean, checked, and properly maintained.
- The provider must ensure that care and treatment records contain detailed descriptions of how patient's identified treatment needs are to be met.
- The provider must ensure that physical healthcare checks and physical healthcare entries are consistently recorded in their electronic care and treatment records.
- The provider must ensure that all positive behaviour support plans are based on a full assessment of patient need.
- The provider must ensure that all staff take their breaks in line with their own policy.

### Action the provider SHOULD take to improve

- The provider should ensure that all staff engage with patients to help develop their individual rehabilitative skills.
- The provider should consider using a recognised modified early warning system to monitor patients' physical healthcare deterioration.
- The provider should work with key stakeholders to reduce the number of delayed discharges.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**The provider did not ensure that patients received person centred care**<br>• The provider had not ensured that care and treatment records contained detailed descriptions of how patient's identified treatment needs were to be met.<br>• The provider had not ensured that all positive behaviour support plans were based on a full assessment of patient need.<br>This was a breach of regulation 9 |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**The provider did not ensure that patients received safe care and treatment**<br>• The provider had not ensured that physical healthcare checks and physical healthcare entries were consistently recorded in their electronic care and treatment records.<br>This was a breach of regulation 12 |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>**The provider did not ensure that patients received care in safe and clean premises.**<br><br>• The provider had not ensured that all areas of the hospital were safe and clean.<br>• The provider had not ensured that all clinic equipment was clean, checked, and well maintained.<br><br>This was a breach of regulation 15 |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>**The provider did not ensure that patients received care from adequate numbers of staff at all times.**<br><br>• The provider had not ensured that all staff took their breaks in line with their own policy.<br><br>This was a breach of regulation 18 (1) |