

Requires improvement 

Leicestershire Partnership NHS Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RT5NH	The Agnes Unit	The Agnes Unit	LE7 7GX
RT5FP	Short Breaks – Farm Drive	The Gillivers	LE3 9QF
RT5FP	Short Breaks – Farm Drive	1 The Grange	LE3 9QF
RT5FM	Short Breaks – Rubicon Close	3 Rubicon Close	LE12 7DJ

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- There were not always enough staff who were suitably qualified and experienced to safely meet patients' needs.
- Mobility and healthcare equipment took up space in The Gillivers and 3 Rubicon Close. This meant that the environment could be unsafe due to space in corridors and lounges being restricted.
- Some risk assessments had not been reviewed regularly at The Grange.
- Staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.
- Records about the use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were inconsistent. Staff were not aware of how this might affect the safety and rights of the patients.
- Some staff did not receive regular supervision or annual appraisals.
- Staff had limited opportunities to receive specialist training.
- In 3 Rubicon Close, it was not clear that information about providing physiotherapy to a patient had been communicated to all staff.

- The short breaks service was primarily set up to meet the needs of relatives and carers. There was no funding for staff to provide activities so patients had limited access to activities of their choice during their stay.
- Two patients' discharges were delayed at The Agnes Unit because the commissioners could not find specialist placements.

However:

- Restraint was used only as a last resort.
- Medicine management practices were safe.
- Staff received training in safeguarding and knew how to report when needed.
- All incidents that should be reported were reported.
- Multi-disciplinary teams and inter agency working were effective in supporting patients. Best interest meetings were held where it had been assessed that a patient lacked the capacity to consent to a decision.
- Staff were very caring and sensitive to patients' needs. Staff had a good understanding of patients' needs. Patients' families and carers were positive about the care provided.
- Patients were supported to meet their religious and cultural needs. Interpreters were available.
- Staff knew the vision and values of the trust and agreed with these. They were reflected in the objectives of local teams.

Summary of findings

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

Are services safe?

We rated safe as **requires improvement** because:

- There were not always enough staff who were suitably qualified and experienced to safely meet patients' needs.
- Mobility and healthcare equipment took up space in The Gillivers and 3 Rubicon Close. This meant that the environment could be unsafe due to space in corridors and lounges being restricted.
- Some risk assessments had not been reviewed regularly at The Grange.

However:

- Restraint was used only as a last resort. There were clear records kept when a patient was secluded on The Agnes Unit.
- Medicine management practices were safe.
- Staff received training in safeguarding and knew how to report when needed.
- All incidents that should be reported were reported.

Requires improvement



Are services effective?

We rated effective as **requires improvement** because:

- Staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.
- Records about the use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were inconsistent. Staff were not aware of how this might impact on the safety and rights of the patients.
- Some staff did not receive regular supervision.
- Staff had limited opportunities to receive specialist training.
- Not all records had been transferred to one system in The Agnes Unit which could impact on the effectiveness of individual's care and treatment.
- In 3 Rubicon Close it was not clear that information about providing physiotherapy to a patient had been communicated to all staff.

However:

- Multi-disciplinary teams and inter agency working were effective in supporting patients.
- Best interest meetings were held where it had been assessed that a patient lacked the capacity to consent to a decision.

Requires improvement



Summary of findings

Are services caring?

We rated caring as **good** because:

- Staff were very caring.
- Staff were sensitive to patients' needs.
- Patients' families and carers were involved in their care.
- Advocacy services were involved.

However:

- When families were involved it was not clear that the patient always wanted this.
- There was one shared bedroom in 3 Rubicon Close which did not ensure the privacy of patients when using the short break service.

Good



Are services responsive to people's needs?

We rated responsive as **good** because:

- Staff on the wards supported patients to meet their religious and cultural needs.
- Interpreters were available.
- Patients and their relatives or carers knew how to make a complaint.
- Staff on the wards made adjustments to ensure that all patients with different needs were able to access the service.
- The activity timetable at The Agnes Unit was flexible.
- Relatives and carers had the number of short stays they requested during the year.

However:

- Staff to provide activities were not funded and patients had limited access to activities of their choice during their stay in the short break service. Most patients attended their usual day care provision during their stay.
- Two patients' discharges were delayed at The Agnes Unit because the commissioners could not find specialist placements.

Good



Are services well-led?

We rated **well-led** as good because:

- Staff understood the vision and values of the trust. They were reflected in the objectives of local teams.
- Systems were in place to ensure staff received mandatory training.
- There was evidence that incidents were learnt from.

Good



Summary of findings

- Some staff had good opportunities for professional development.
- Staff knew how to use the whistle blowing process and were able to raise concerns without fear of victimisation.
- There was team working and mutual support.

However:

- Some staff did not receive regular supervision or appraisals.

Summary of findings

Information about the service

The wards for people with learning disabilities and autism provided by Leicestershire Partnership Trust are based on three sites. The 3 short breaks homes are mixed sex accommodation and the Agnes Unit is also mixed sex. However, within all the units areas are zoned to single sex as required

The Agnes Unit is commissioned to provide 16 beds for individuals whose mental health, behaviour and level of risk cannot be supported in the community. The unit is divided into five pods with communal areas and four ensuite bedrooms on each.

The Gillivers provides short breaks for up to six adults who have a learning disability and associated physical and sensory disabilities.

The Grange provides short breaks for up to five adults who have a learning disability, behaviours that may challenge the service or autism. This is next door to The Gillivers.

3 Rubicon Close provides short breaks for up to six adults who have a learning disability and associated physical and sensory disabilities.

The Agnes Unit was inspected in 2010.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting

The team that inspected wards for people with learning disabilities and autism consisted of nine people: two inspectors, one nurse, one Mental Health Act reviewer, a speech and language therapist, a psychologist, a social worker, an occupational therapist and a junior doctor.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

Summary of findings

- visited the Agnes Unit and 3 respite care facilities and looked at the quality of the environment and observed how staff were caring for patients
- spoke with nine patients
- spoke with the managers or acting managers for each of the wards
- spoke with 32 other staff members; including doctors, nurses and occupational therapists
- interviewed the therapy lead and practice development nurse
- attended and observed three multi-disciplinary meetings. Spoke on the telephone with 12 relatives or carers of patients
- looked at 14 treatment records of patients and five patients' medication records
- carried out a specific check of the medication management on four wards
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Patients told us that the staff were helpful and kind.

Patients said that they liked going to the short breaks service and were happy.

Two patients at The Agnes Unit told us they did not always feel safe because of the behaviour of another patient.

Some patients were unable to communicate their views about the service due to their needs. We spoke with their relatives or carers and asked for their views.

Relatives told us that staff in the short breaks service looked after their family member well and the patients were happy to go there. They said there were enough staff.

One carer told us that staff managed their relative's behaviours well without the need to use extra medication.

Relatives and carers told us that staff in The Agnes Unit looked after their relative very well and felt their relative was safe there. They said that staff supported their relative to keep in contact with them. They said that staff were helpful and kind and there were always enough staff.

All relatives and carers told us they had no concerns about the service but would know how to make a complaint if they needed to. They thought they would be listened to if they needed to raise concerns.

Good practice

- The Agnes Unit had received some charitable funding and had used this to buy African drums and fund a session leader. We observed a session where patients enjoyed drumming.
- Students from a local university were working with patients at The Agnes Unit on art work which would be displayed in the corridors.
- The chaplaincy service had worked particularly well with one patient. This involved sensitive work in how their religious needs were to be met when they were discharged into the community.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust MUST ensure there are sufficient, suitably qualified and experienced staff to meet patients' needs safely.
- The trust MUST ensure that all staff are aware of the implications of the MHA and the MCA and how it affects patients' safety and rights.

Summary of findings

- The trust **MUST** ensure that all risk assessments are reviewed regularly and updated to reflect patients' changing needs.

Action the provider SHOULD take to improve

- The trust should review the number of patients using the services at The Gillivers and 3 Rubicon Close at any one time to ensure the environment is safe.
- The trust should only share information about patients with their families and carers when it is in the patients' best interests.

- The trust should review whether the shared bedroom in 3 Rubicon Close is suitable to be used for patients accessing a short break service.
- The trust should ensure that all patients are given the opportunity to be involved in their care plans.
- The trust should adapt relevant Recovery College programmes for people who have a learning disability.
- The trust should ensure that all staff receive regular supervision and have an annual appraisal.
- The trust should review the purpose and financial sustainability of the short breaks services. This should include looking at what individual activities can be provided to meet patients' needs.

Leicestershire Partnership NHS Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Agnes Unit	The Agnes Unit
The Gillivers	Short Breaks- Farm Drive
1 The Grange	Short Breaks- Farm Drive
3 Rubicon Close	Short Breaks – 3 Rubicon Close

Mental Health Act responsibilities

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

- Patients who used the short breaks services were not detained under the MHA.
- Staff received training in the MHA as part of their mandatory training.
- In two of four records we looked at there was no evidence that patients had their rights under the MHA explained to them on admission or routinely thereafter.
- Two patients' records showed that their capacity to consent to their treatment under the MHA had been assessed. However, in two patients' records there was no evidence that this had been assessed.
- Copies of detention paperwork were not kept on the patients' files.
- One patient who was admitted in January 2013 had been out of the hospital on escorted and unescorted leave. However, there was no authorisation for this leave in their records. Staff were unsure of the patient's leave arrangements. During our inspection staff obtained the authorisation from the relevant authority.
- For two other patients detained under the MHA there were no outcomes recorded of how their leave had gone and the patients' views were not recorded. This could risk the safety of the patient and others when accessing leave from the hospital.

Detailed findings

- There were posters displayed on the unit about the IMHA service. However, patient's records did not show that they had been informed of their right to access the IMHA services.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were trained in and most staff had a good understanding of the Mental Capacity Act (MCA) 2005.
- In two of the four patient records we looked at in The Agnes Unit there was no evidence that the patient's capacity to consent to decisions had been assessed.
- In the short breaks services assessments of patients' mental capacity to consent to decisions had been completed. These were specific to decisions that needed to be made.
- We observed good use of the MCA in the multi-disciplinary team meetings.
- Staff liaised with best interest assessors and best interests meetings were held where appropriate. Where patients lacked the capacity to consent, decisions were made in their best interests.
- Staff knew where to get advice regarding MCA, including the Deprivation of Liberty Safeguards (DoLS) within the trust.
- In 3 Rubicon Close independent mental capacity advocates (IMCA's) were regularly involved in patients' reviews.
- DoLS applications had been made when required. However, records in The Agnes Unit were inconsistent in recording these. In two of three patients' records there was no evidence that the DoLS application had been authorised. It was not possible to clarify the dates when the applications had been made. Staff told us that they had applied for a standard DoLS for two patients, one had been approved but the other was still pending.
- In The Grange three DoLS applications had been made. Two of these had been authorised and the other was declined in September 2014. Staff were not aware of this until we brought this to their attention.

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement because:

- There were not always enough staff who were suitably qualified and experienced to safely meet patients' needs.
- Mobility and healthcare equipment took up space in The Gillivers and 3 Rubicon Close. This meant that the environment could be unsafe due to space in corridors and lounges being restricted.
- Some risk assessments had not been reviewed regularly at The Grange.

However:

- Restraint was used only as a last resort. There were clear records kept when a patient was secluded on The Agnes Unit.
- Medicine management practices were safe.
- Staff received training in safeguarding and knew how to report when needed.
- All incidents that should be reported were reported.

- The seclusion room allowed clear observation, two-way communication and had toilet facilities. There was no clock in the room. However, staff were instructed to put a clock on a chair at the window so that patients could see this.
- All ward areas were clean, had good furnishings and were well maintained.
- Staff had access to appropriate alarms to summon assistance from other staff when needed.

Safe staffing

- The provider had estimated the number and grade of nurses required using a recognised tool. The number of nurses matched this number on most shifts. The team manager told us that on two shifts in the last month the staffing numbers had been unsafe. However, the Manager told us that Matrons and the Manager had worked shifts to ensure safe staffing was maintained.
- The team manager told us that the staffing situation was on the directorate's risk register. There were 15 nursing assistant posts vacant however these could only be advertised as temporary posts as the number of beds had not been confirmed. This was because the unit had only been commissioned to provide 16 beds in a 20 bed unit.
- Bank and agency staff were used to cover vacancies. Staff told us that this was usually staff who were familiar with the ward. However, on the day of our inspection there were two new bank staff working with a patient. The patient's risk assessment stated that staff who knew them well must work with the patient to reduce their anxiety. There was a risk of the patient assaulting new staff. One of the new staff had been assaulted by the patient earlier that day.
- Activity staff were in addition to the safe staffing levels so would be used to cover shifts if needed. However this would impact on the activities patients could do.
- When the ward was short-staffed staff were not able to have their breaks. Day staff worked eight hour shifts so were entitled to a 30 minute break. Staff said that sometimes they did not get their full breaks away from the units, but they always had time to have drinks or food on the pod.

Our findings

The Agnes Unit

Safe and clean ward environment

- Environmental risk assessments were undertaken regularly.
- The layout meant that not all parts of the ward could be observed. However CCTV cameras had been installed to mitigate this risk so that the seclusion room and all communal corridors outside of the pods could be safely observed.
- Ligature points in the four pods commissioned to be used by The Agnes Unit had been identified and action taken to mitigate these risks.
- The ward complied with Department of Health and other guidance on same sex accommodation.
- There was a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that were checked regularly.

Are services safe?

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

- Junior doctors told us that the rota for cover was not learning disability specific. They thought there was a risk that a specialist learning disability doctor would not be available when needed, but the trust told us that there was an LD doctor on call.

Assessing and managing risk to patients and staff

- Staff undertook a risk assessment of every patient on admission and updated this regularly and after every incident using a recognised risk assessment tool
- Blanket restrictions were only used when justified. For example, patients only used the gardens and outside space when supported by staff due to the ligature risks identified there. None of the patients or staff we spoke to said this restricted patients' access to outside space.
- There were policies and procedures for the use of observation and searching patients on their return from leave.
- Restraint was only used after de-escalation had failed and correct techniques were used. Staff were trained in positive behaviour support (PBS) and used this to reduce the need for restraint.
- Bank and agency staff were trained in the use of managing actual and potential aggression (MAPA).
- Use of rapid tranquilisation followed NICE guidance.
- We examined records for seclusion and found that seclusion was used appropriately and followed best practice. Seclusion had been used seven times in the last year. A post seclusion review was held after each episode.
- There was good use of the guidance on reducing restrictive practice. For example, there had been an incident on the day of our inspection where a patient had assaulted a staff member. Staff used de-escalation techniques to help the patient to calm down.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and did this when appropriate.
- There was good medicines management practice.
- Staff were aware of and addressed any outlier issues such as falls or pressure ulcers.
- There were safe procedures for children that visited the unit.

Track record on safety

- There had been incidents where a patient had been assaulted by another patient. Safeguarding alerts had been made appropriately in response to this. Staffing

had been increased to reduce incidents. Two patients told us they felt unsafe because they had been hurt by another patient. Staff said they had assessed whether it would be possible to move patients to other pods but this did not reduce the risks to patients in those pods.

Reporting incidents and learning from when things go wrong

- All staff know what to report and how to report and all incidents that should be reported were reported.
- Staff told us that they received feedback from investigation of incidents both internal and external to the service. Staff met to discuss this feedback. There was evidence of change having been made as a result of feedback.
- Staff were debriefed and offered support after serious incidents.
- Staff we spoke with were aware of the duty of candour responsibility

The Gillivers, 1 The Grange, 3 Rubicon Close

Safe and clean ward environment

- There were fully equipped clinic rooms with emergency drugs that were checked regularly.
- The wards complied with guidance on same sex accommodation.
- All ward areas were clean.
- There were unsafe areas in the lounge in 3 Rubicon Close for patients who had epilepsy. For example, the fire guard was freestanding and not secured. There were also sharp edges on some of the furniture which could cause injury if a patient fell. Staff said that patients were supervised at all times when in the lounge to reduce these risks.
- Space was limited in the lounges at The Gillivers and 3 Rubicon Close. Each patient brought with them specialist mobility and healthcare equipment to meet their needs. Staff told us that if all the beds were full there was a risk to patient and staff safety if all patients used the lounge at the same time.

Safe staffing

- In The Gillivers the agreed ratio of patient to staff meant that they were not able to safely meet patients' needs.

Are services safe?

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

The current acuity tools used to determine the number of staff needed did not meet the needs of the patients who used this service. This had been raised as a risk with senior management.

- At The Grange and The Gillivers there were not enough qualified nurses employed to always have a qualified nurse on each shift. Staff at The Gillivers told us that 9 times out of 10 there was a qualified nurse. Nursing assistants were trained in administering medication, enteral feeding and care of tracheostomy. They had been assessed as competent to do these.
- At The Grange staff told us that they always aimed to have a qualified nurse on duty on Mondays and Fridays. These were the busy times when patients were admitted or discharged. Staff in The Gillivers told us that bank staff did not always have the right skills they needed to meet each patient's needs. This was due to delays in them receiving the specialist training. Only bank staff that knew the service at The Grange worked there so they would have the skills and knowledge to safely support patients.
- At 3 Rubicon there were two nursing assistant vacancies which were covered by bank staff. There was also a vacancy for a housekeeper and these duties were covered by nursing staff.

Assessing and managing risk to patients and staff

- Staff undertook a risk assessment of every patient on each admission and updated this regularly and after every incident. However, in two patients' records at The Grange their risk assessments had not been reviewed on each admission. They had been reviewed by community teams. However, the risks assessed may be different in each environment.
- Each patient had an assessment of what support they would need if the premises needed to be evacuated in an emergency.

- Staff were trained in safeguarding and knew how to make a safeguarding alert and did this when appropriate.
- There was good medicines management practice. Staff contacted relatives and carers a few days before the patient's admission. This ensured they had updated information about the patients prescribed medication and these were available to them on admission.
- At The Grange and 3 Rubicon staff were trained in the use of Strategies for Crisis Intervention and Prevention (SCIP). At 3 Rubicon six staff needed updated training in this but there was no record that this had been completed. However, this was rarely used at 3 Rubicon due to the needs of patients.
- Staff were trained in how to use rapid tranquilisation but it was not used.

Track record on safety

- In 3 Rubicon there were some reports of patients' property going missing during their stay or not being returned to the correct patient. Two patients' records included a property list that had not been signed by staff to indicate what property the patient had on admission. This meant it was unclear as to what property belonged to whom.

Reporting incidents and learning from when things go wrong

- All staff knew what to report and how to report. All incidents that should be reported were reported.
- Staff received feedback from the investigation of incidents
- There was evidence of change having been made as a result of feedback.
- Staff were debriefed and offered support after serious incidents.
- Staff we spoke with were aware of the duty of candour responsibility

Are services effective?

Requires improvement 

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

Summary of findings

We rated effective as **requires improvement** because:

- Staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.
- Records about the use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were inconsistent. Staff were not aware of how this might impact on the safety and rights of the patients.
- Some staff did not receive regular supervision.
- Staff had limited opportunities to receive specialist training.
- In 3 Rubicon Close it was not clear that information about providing physiotherapy to a patient had been communicated to all staff.

However:

- Multi-disciplinary teams and inter agency working were effective in supporting patients.
- Best interest meetings were held where it had been assessed that a patient lacked the capacity to consent to a decision.

- There was evidence in medication records that staff followed NICE guidance when prescribing medication.
- Clinical care pathways such as epilepsy, forensic and challenging behaviour were underpinned by NICE guidance. This provided continuity to learning disability community services.
- Psychiatrists did physical health checks for all patients. Junior doctors expressed concern that long term physical health care could be compromised for long term patients as patients were not seen by a general practitioner.
- Specific treatment programmes had been adapted for people with a learning disability to ensure these were effective for the patient.
- The trust has a recovery college. However, this was not adapted for people with a learning disability. None of the patients accessed this.
- There was limited psychology support. The psychologist told us that they did not have enough time to work with all the patients who needed this input. They said that waiting times for psychology was on the trust risk register.

Skilled staff to deliver care

- A range of learning disability professionals and workers provided input to the unit. These included psychiatrists, speech and language therapists, psychologists and occupational therapists.
- Permanent staff were experienced and qualified and received mandatory training. Not all bank staff had received this. Staff were not supervised as regularly as planned due to staffing vacancies.
- Occupational therapists said they received professional specialist training. However, nurses told us that they often only received the mandatory training and did not have the opportunity to do specialist training.

Multi - disciplinary and inter-agency team work

- Multi-disciplinary meetings were regular and effective.
- There were effective handovers between each shift.
- Working relationships with other teams in the organisation, for example care co-ordinators and community teams were effective

Adherence to the MHA and MHA Code of Practice

- Staff received training in the MHA as part of their mandatory training.

Our findings

The Agnes Unit

Assessment of needs and planning of care

- A comprehensive and timely assessment was completed on each patient.
- Records showed that a physical examination of each patient had been undertaken and there was ongoing monitoring of physical health problems. Annual health checks had been completed for patients who were admitted on a long term basis.
- Each patient had a 'my Agnes care plan.' These were detailed and person centred.
- There was a backlog in getting patients records onto RIO (electronic records system) so some records were still on paper. It was not always clear what the current risks for each patient were. Bank and agency staff were not able to access RIO. This meant that not all staff working with the patient knew the risks and how to support them to reduce these.

Best practice in treatment and care

Are services effective?

Requires improvement 

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

- In two of four records we looked at there was no evidence that patients had their rights under the MHA explained to them on admission or routinely thereafter.
- Two patients' records showed that their capacity to consent to their treatment under the MHA had been assessed. However, in a further two patients' records there was no evidence that this had been assessed.
- Copies of detention paperwork were not kept on the patients' files.
- One patient who was admitted in January 2013 had been out of the hospital on escorted and unescorted leave. However, there was no authorisation for this leave in their records. Staff were unsure of the patients leave arrangements. During our inspection staff obtained the authorisation from the relevant authority.
- For two other patients detained under the MHA there were no records of how their leave had gone and the patients view had not been recorded. This could risk the safety of the patient and others when accessing leave from the hospital.
- There were posters displayed on the unit about the independent mental health advocacy service. However, patient's records did not show that they had been informed of their right to access the IMHA services.

Good practice in applying the MCA

- Staff were trained in, and most staff had a good understanding of, the MCA 2005.
- In two of the four patient records we looked at there was no evidence that the patients' capacity to consent to decisions had been assessed. However, where capacity had been assessed this was good practice.
- We observed good use of the MCA in the multi-disciplinary team meetings.
- Staff liaised with best interests assessors and best interests meetings were held where appropriate.
- Staff understood, and where appropriate worked within, the MCA definition of restraint.
- Staff knew where to get advice regarding MCA, including DoLS, within the trust.
- Deprivation of Liberty safeguards applications had been made when required. However, records were inconsistent in recording these. In two of three patients' records there was no evidence that the DoLS application had been authorised. It was not possible to clarify the

dates when the applications had been made. Staff told us that they had applied for a standard DoLS for two patients, one had been approved but the other was still pending.

The Gillivers, 1 The Grange, 3 Rubicon Close

Assessment of needs and planning of care

- Patients were assessed when they were referred to the service to ensure their needs could be met there.
- Care plans were person-centred, regularly reviewed and updated where appropriate.
- Patients' physical health observations were completed by nurses on admission and discharge and monitored during their stay where needed.

Best practice in treatment and care

- Patients did not always have access to their own GP while they were using the service depending on where their home was. Their physical healthcare needs were monitored by the psychiatrist or local community health services during their stay.

Skilled staff to deliver care

- Staff had received the mandatory training they needed to fulfil their job role. This included enteral feeding and tracheostomy care in 3 Rubicon and The Gillivers. However, staff told us that opportunities to do other specialist training were limited.
- Staff at 3 Rubicon did not receive regular supervision and did not have regular team meetings. They were signposted to information via the communication book but it was not recorded which staff had read the information they needed to.
- In The Grange staff received regular supervision. Staff had a good induction where they shadowed other staff for two weeks before being included in the numbers for the shift.

Multi-disciplinary and inter-agency team work

- In 3 Rubicon there were clear links with the community outreach team, occupational therapists (OT) and physiotherapists. They had input into patients' care plans. However, we saw that information about patients was not always shared. For example, one patient's physiotherapy and OT plan was not available. The patient needed chest physiotherapy. The

Are services effective?

Requires improvement 

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

physiotherapist went to the unit to show staff how to do this but this was not recorded in the patient's notes.

Therefore, staff who were not present when the physiotherapist visited would not know how to do this.

- In 3 Rubicon we saw there were links with the dietician. They had worked with staff to develop individual eating and drinking plans for patients. Guidance and processes were available for patients who needed enteral feeding.
- The Grange had good links with the learning disability community teams. Staff said that support was usually available when asked for.
- A physiotherapist visited The Gillivers three times a week to treat patients and offer advice to staff.

Adherence to the MHA and MHA Code of Practice

- The patients who used these services were not detained under the MHA.

Good practice in applying the MCA

- Staff were trained in and generally had a good understanding of the MCA 2005.
- Assessments of patients' mental capacity to consent to decisions had been completed. These were specific to decisions that needed to be made.
- Where patients lacked the capacity to consent decisions were made in their best interests.
- In 3 Rubicon IMCAs were regularly involved in patients' reviews.
- In The Grange three DoLS applications had been made. Two of these had been authorised and the other was declined in September 2014. Staff were not aware of this until we brought this to their attention.

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- Staff were very caring.
- Staff were sensitive to patients' needs.
- Patients' families and carers were involved in their care.
- Advocacy services were involved.

However:

- When families were involved it was not clear that the patient always wanted this.
- There was one shared bedroom in 3 Rubicon Close which did not ensure the privacy of patients when using the short break service.

Our findings

The Agnes Unit

Kindness, dignity, respect and support

- We observed that staff interacted with patients in a respectful way and provided appropriate practical and emotional support.
- Patients and their relatives or carers told us that staff treated them well and treated them with dignity and respect.
- Staff understood the individual needs of patients.

The involvement of people in the care they receive

- The admission process informed and orientated the patient to the ward and the service.

- Three of five patients records looked at showed that the patient was not involved in their care plan. The other two records showed that the patient was involved.
- We observed that one patient was very involved in their review meeting and what they wanted was discussed.
- Patients had access to advocacy services. The occupational therapist was running an advocacy group with Mencap.
- There was appropriate involvement of families and carers.

The Gillivers, 1 The Grange, 3 Rubicon Close

Kindness, dignity, respect and support

- We observed that staff interacted with patients in a responsive, respectful way and provided appropriate practical and emotional support.
- There was (only) one shared bedroom in 3 Rubicon which could affect patients' privacy when using the service for a short break.
- Patients and their relatives or carers told us that staff treated them well and treated them with dignity and respect.
- Staff understood the individual needs of patients.

The involvement of people in the care they receive

- The admission process informed and orientated the patient to the ward and the service.
- Families and carers were involved in the service. However, on discharge the family or carer were given a copy of what the patient had done during their short break. It was not clear whether the wishes of the patient had been considered in this and wanted all this information shared.

Are services responsive to people's needs?

Good 

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

Summary of findings

We rated responsive as **good** because:

- Staff on the wards supported patients to meet their religious and cultural needs.
- Interpreters were available.
- Patients and their relatives or carers knew how to make a complaint.
- Staff on the wards made adjustments to ensure that all patients with different needs were able to access the service.
- The activity timetable at The Agnes Unit was flexible.
- Relatives and carers had the number of short stays they requested during the year.

However:

- Staff to provide activities were not funded and patients had limited access to activities of their choice during their stay in the short break service. Most patients attended their usual day care provision during their stay.
- Two patients' discharges were delayed at The Agnes Unit because the commissioners could not find specialist placements.

- There was a full range of rooms and equipment to support treatment and care.
- Quiet areas were provided.
- There was a room on the unit where patients could meet with their visitors.
- Patients could make a phone call in private.
- Patients who had been at the unit on a long term basis told us they did not like the food as the range of choices was limited.
- There was access to activities seven days a week unless activity staff were needed to cover shifts. There was an ongoing activity timetable that included three evenings a week.
- The occupational therapy (OT) and activity team on the unit had been operating for only a couple of months. However, the OT model used - model of creative ability (MOCA) was a recognised model that could benefit patients. OTs used a specific interest checklist for people who have a learning disability. The OT was trained in sensory integration to enable them to meet patients' needs.

Meeting the needs of all people who use the service

- The unit had been purpose built. It was on the ground floor and there was easy access around the corridors and pods.
- Patients received a welcome pack on admission which was in a format that included pictures making it easier to understand. A pack for relatives and carers was being developed.
- We saw that adjustments were made to enable a patient to participate in their review meeting and have an understanding of the process.
- There was easy access to interpreters.
- There was a choice of food to meet patients' religious and cultural needs.
- Patients had access to appropriate spiritual support. We saw that the chaplaincy service had worked well with a patient to meet their religious needs.

Listening to and learning from concerns and complaints

- Patients and their relatives or carers knew how to complain.
- Staff knew how to handle complaints appropriately.
- Staff received feedback on the outcome of the investigation of complaints and acted on the findings.

Our findings

The Agnes Unit

Access, discharge and bed management

- Patients were not moved around pods during an admission unless this was justified on clinical grounds and was in the interests of the patient.
- When patients were moved or discharged this happened at an appropriate time of day.
- Discharge was delayed for two patients due to commissioners not being able to find suitable specialist placements. Staff had been proactive in liaising with commissioners about the impact this had on these patients.
- Discharge of other patients was not delayed other than for clinical reasons.

The ward optimises recovery, comfort and dignity

Are services responsive to people's needs?

Good 

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

The Gillivers, 1 The Grange, 3 Rubicon Close

Access, discharge and bed management

- There was access to the service when requested by each relative or carer. Each relative or carer was sent a request form at the beginning of the year where they could request 56 nights of stay. Relatives and carers told us the service always met their requests.
- Admissions were planned where possible to ensure that each patient would get on with other patients who were staying at the same time. The services met planned and emergency demand.
- The trust provided us with data for the occupancy of the service. This was accurate at the end of January 2015: The occupancy of The Gillivers was 41%, The Grange 41% and 3 Rubicon 70%. This showed low occupancy rates over the year which meant that the service could be financially unsustainable.

The ward optimises recovery, comfort and dignity

- The Gillivers and 3 Rubicon had appropriate facilities and premises for the service provided. However, there was a lack of storage space and space in the lounge was limited when all patients were there.
- The corridors were narrow in The Grange which could make it difficult to restrain a patient if needed.
- Patients were able to bring in their personal possessions during their stay.
- Staff cooked the meals on each unit. Menus showed that a variety of food was offered.
- The units were not funded to provide staff to engage patients in activities. Staff said that they tried to engage

patients in activities when possible. However, some patients needed a lot of physical care so this could be limited. Most patients attended their usual day care provision during their stay.

Meeting the needs of all people who use the service

- Adjustments were made for patients who required disabled access. There were overhead hoists provided at The Gillivers and 3 Rubicon Close. Accessible bathrooms were provided.
- Patients were invited to visit the service when they were referred. We saw that adjustments were made to this for one patient at The Grange who had autism. Staff went to visit the patient at their home to introduce them to staff. They took photographs of the service and other staff. This helped the patient to be introduced to the service before they were admitted for the first time.
- There was easy access to interpreters.
- There was a choice of food to meet patient's religious and cultural needs.
- The service was set up primarily to meet the needs of relatives and carers and give them respite when needed. It was not clear how patients' individual aspirations and goals were met during their stay.

Listening to and learning from concerns and complaints

- Patients and their relatives or carers knew how to complain.
- Staff knew how to handle complaints appropriately.
- Staff received feedback on the outcome of the investigation of complaints and acted on the findings.

Are services well-led?

Good 

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

Summary of findings

We rated **well-led** as good because:

- Staff understood the vision and values of the trust. They were reflected in the objectives of local teams.
- Systems were in place to ensure staff received mandatory training.
- There was evidence that incidents were learnt from.
- Some staff had good opportunities for professional development.
- Staff knew how to use the whistle blowing process and were able to raise concerns without fear of victimisation.
- There was team working and mutual support.

However:

- Some staff did not receive regular supervision or appraisals.

Our findings

The Agnes Unit

Vision and values

- Staff knew and agreed with the trust's values.
- Team objectives reflected the trust's values and objectives.

Good governance

- Staff received mandatory training.
- Some staff did not have regular supervision.
- There was a new on line appraisal system called U-learn and staff were positive about this.
- Incidents were reported.
- Staff learnt from incidents, complaints and patients' feedback.
- The team manager had sufficient authority and admin support.
- Staff have the ability to submit items to the trust risk register.

Leadership, morale and staff engagement

- The average sickness rate as at January 2015 for the unit was 4.4%. This was rated as green which was not considered to be a risk.

- Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation.
- Staff were positive about their job and had a sense of empowerment.
- Qualified and professional staff had opportunities to input into service development and leadership work. Unqualified staff said they did not always have opportunities to do more than the mandatory training provided.
- There was team working and mutual support.
- There were clear lines of responsibility and staff knew who was leading the learning disability service.

Commitment to quality improvement and innovation

- The unit was accredited by AIMS - LD (Accreditation for Inpatient Mental Health Services).

The Gillivers, 1 The Grange, 3 Rubicon Close

Vision and values

- Staff knew and agreed with the trust's values.
- Team objectives reflected the trust's values and objectives.
- At 3 Rubicon staff told us they received regular emails and updates from senior management.

Good governance

- Staff at 3 Rubicon did not have regular supervision or appraisals. Staff said that the manager was responsible for two of the services: 3 Rubicon and The Gillivers and therefore was not always accessible.

Leadership, morale and staff engagement

- The average sickness rates as at January 2015 for the short breaks services were 5.6% overall. This was 7.7% for The Grange, 7% for The Gillivers and 1.4% for 3 Rubicon. The Grange and The Gillivers were assessed in the red category as being high rates.
- Staff at The Grange told us that there had been long term sickness for reasons unrelated to work. They said the managers had been very supportive during this time.
- Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation.
- Staff were positive about their job role.
- There was team working and mutual support.

Commitment to quality improvement and innovation

Are services well-led?

Good 

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

- Some staff told us that now the learning disability services were part of the adult mental health directorate

they felt that they were the Cinderella service. However, other staff told us that this was positive as they had access to more networks and there were more opportunities for development.

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

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing

Regulation 22 HSCA 2008 (Regulated activities)

Regulations 2010

Staffing

The trust did not take appropriate steps to ensure there were sufficient numbers of staff.

- Not all community and inpatient services had sufficient staffing to safely meet patient need.
- Not all services had access to specialist medical support in a timely way.

This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities)
Regulations 2010 Supporting staff

Regulation 23 HSCA 2008 (Regulated activities)

Regulations 2010

The trust had not made suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities, including receiving appropriate training, professional development, supervision and appraisal.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

Regulations 18 HSCA 2008 (Regulated activities) Regulations 2010

Consent to care and treatment

The trust did not make appropriate arrangements to ensure the consent to care and treatment of all services users.

- Not all staff were aware of procedures required under the Mental Capacity Act or the Mental health Act.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.