Inadequate

Cumbria Partnership NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNNBJ	The Carlton Clinic	Edenwood Ward	CA1 3SX

This report describes our judgement of the quality of care provided within this core service by Edenwood Ward. 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 Cumbria Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cumbria Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Staff had limited access to specialist training to ensure patient needs could be met effectively.
- There was no formal process for learning when things went wrong or when incidents occurred.
- The ward did not have any plans in place to evaluate and minimise the use of restrictive practice.
- Management of medication required some improvements.
- Care and treatment was not planned and delivered in line with best practice guidance.
- Care plans were not holistic, person-centred or treatment focused.
- There was limited assessment of patients communication needs across the ward.
- None of the patients had a discharge plan in place.
- The clinical leadership on the ward was not clear and all staff reported that they felt the ward felt disorganised and chaotic.
- Only 11% of non-clinical staff had received supervision and appraisal
- Only 71% of staff had received mandatory training.

However:

- There was sufficient staff on duty to ensure the safety and well-being of patients.
- Each patient had a comprehensive risk assessment in place that was up to date.
- The service carried out audits of ligature points (fixed objects/fittings where someone might tie something with intent to strangle themselves) and where they were identified action was taken to minimise the risk of harm.
- The ward was spacious, clean and safe.
- Staff were caring and treated patients with dignity and respect.
- Complaints were listened and responded to appropriately.
- Patients had health action plans in place, and medical needs were responded too.
- Staff were aware of the trust vision and values and acknowledged the service required improvements but were committed to providing good care to patients.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There were no call bells or alarm systems around the ward or in patient bedrooms.
- There was no formal process from learning from incidents or where things went wrong.
- There was no plan in place to reduce physical interventions or restrictive practice.
- Pharmacists' audits did not formally feedback to ward staff.
- Mandatory training was not meeting the trust standard of 80%, however, the ward were taking action to address this.

However:

- Each patient had a comprehensive risk assessment in place that was up to date.
- There was sufficient staff on duty to ensure the safety and well-being of patients
- The service carried out audits of ligature points (fixed objects/ fittings where someone might tie something with intent to strangle themselves) and where they were identified action was taken to minimise the risk of harm.
- The ward was spacious, clean and safe.

Are services effective?

Inadequate

We rated effective as Inadaquate because:

- The service did not follow best practice and guidance in prescribing 'as and when required' medication.
- Patients did not receive care and treatment in accordance with their assessed needs.
- There was limited input to support patients with their communication needs and there was no occupational therapy for patients.
- The service did not always meet the expectations of the Mental Capacity Act 2005 because patients' with limited communication were not support adequately in the assessment process.
- Only 11% of non-clinical staff had received an appraisal,
- The service did not have a plan in place for reducing restrictive practice in accordance with Positive and Proactive Care Guidance April 2014.

However:

Summary of findings

- Patients had health action plans in place and full assessments of their physical health needs.
- All documentation relating to patients detained under the Mental Health Act 1983 was correct.

Are services caring?

We rated caring as good because;

- Patients were treated with dignity and respect.
- Patients had access to advocacy services.
- Patients participated in community meetings on the ward. They were able to discuss any issues about the ward and all of these had been addressed.
- Patients and carers were involved in multi disciplinary team meetings, care co-ordination meetings and decision making.

However:

- Care plans did not detail how patients were involved in planning of their care.
- Information provided to patients on admission was not always in a format the patient could understand.

Good

Are services responsive to people's needs?

We rated responsive as requires improvement because;

- Patients did not have a discharge plan.
- There was no formal tool implemented to monitor outcomes for patients.
- Theraputic activities were limited and there was little focus on increasing independence and skill such as promoting the use of daily living skills.

However:

- Patients' spiritual, religious and nutritional needs were met and planned for.
- The ward environment was spacious and patients had access to drinks and snacks.
- Patients knew how to make complaints and where complaints were made these were responded to.

Requires improvement

Are services well-led?

We rated well led as Inadaquate because;

- The service did not have clear focus and staff said the ward management was poor.

Inadequate

Summary of findings

- Staff did not feel their concerns regarding lack of training and support was acted upon
- Sickness levels were at 15% that is higher than the national average of 5%.
- Every member of staff told us their role was exhausting and morale fluctuated because they felt senior managers often dismissed them as a service.

However:

- The ward manger told us they had autonomy to increase staffing levels where required
- The service had received Accreditation for Inpatient Mental Health Services (AIMS).

Summary of findings

Information about the service

Edenwood is a specialist Learning Disability In-Patient Service for male and females and has six assessment and treatment beds. It is situated in the Carlton Clinic in Carlisle.

Our inspection team

The team was led by:

Chair: Paddy Cooney

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team leaders: Brian Cranna, inspection manager (mental health), Care Quality Commission and Sarah Dronsfield, inspection manager (community health), Care Quality Commission

The team that inspected the service comprised of two CQC inspectors, an inspection manager, two specialist advisors which included a nurse and a psychiatrist who specialises in learning disabilities, an expert by experience (a person with a learning disability) and their carer.

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:

- Visited Edenwood ward
- Spoke with three patients who were using the service.
- Spoke with the ward manager.
- Spoke with 11 other staff members; including doctors, nurses, healthcare assistants, psychologist and psychologist assistant.
- Spoke to one carer.
- Looked at four treatment records of patients.
- Looked at three medication charts.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

Two patients we spoke with told us they felt safe on the ward and staff supported them when they did not feel safe. We did not receive any comment cards back from this service.

Two patients told us that staff treated them with dignity and respect and were kind and caring to them. They also told us they often got frustrated with the length of time it took to secure funding for future discharge.

Two patients told us they enjoyed the activities but there was limited things to do. Patients told us they did not have activities cancelled and had no complaints about staffing levels.

Good practice

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve:

The service must ensure that care and treatment is planned and delivered in line with best practice guidance.

The service must ensure that care plans are holistic, person-centred and treatment focused.

The service must ensure that patients' communication needs are adequately assessed.

The service must ensure that patients have a discharge plan in place.

The service must ensure that there is a plan in place to reduce physical interventions and restrictive practice.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

The service should ensure that mandatory training is kept current and ongoing.

Cumbria Partnership NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Edenwood ward	The Carleton Clinic

Mental Health Act responsibilities

Staff showed a good understanding of the Mental Health Act (MHA) despite the fact that 37% of staff had received MHA training; this was below the trust target of 80%.

There were good records of MHA detentions.

Detained patients were informed of their rights.

There was information about the MHA displayed on the walls. However, this was only in non-patient areas.

Consent to treatment under the MHA was correctly recorded.

Mental Capacity Act and Deprivation of Liberty Safeguards

We looked at the care records of all patients. Some patients had limited communication styles and even in some cases were unable to verbally communicate. Although the service did not automatically presume that because patients were unable to verbally communicate they therefore did not have capacity, it was unclear how patients were being supported to be involved and make decisions regarding their care and treatment in the absence of any proper support with communication.

However in relation to one patient staff we spoke to were able to give us examples of how they had appropriately assessed patient capacity. This was in relation to a patient discharge. The service had developed a number of easy read scenarios and reports to consider the patients ability to make decisions regarding future care. The assessment was completed with expertise and was thorough. There was a clear focus the service wanted to protect the rights of individuals.

A total of 95% of staff had had training in the Mental Capacity Act (MCA) as at October 2015. This was meeting the trust target of 80%.

Detailed findings

There was one patient under a deprivation of liberty.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

The ward was a spacious environment, clean and well maintained. There were pictures of the local area fixed to the walls around the ward and the patients' bedrooms. Two patients told us they were given a choice in the pictures placed around the ward and their bedroom. Patients also had access to outside space that they could access on their own or with a member of staff depending on their individual risks.

The service was mixed gender and patients had their own bedrooms with bathroom facilities. Female patients had their own lounge area. The service was complying with Department of Health guidance on eliminating mixed sex accommodation 2010.

The ward had cleaning rotas in place and these were checked weekly to ensure cleaning tasks had been completed correctly. The ward reached 99% for infection control and cleanliness in an audit completed November 2015.

Staff had access to handwashing facilities throughout the ward and hand gels were available. We observed staff washing their hands at appropriate times such as prior to serving meals and giving out medication.

The ward had an up to date ligature risk assessment that was completed by the ward manager and deputy ward manager. Where risks had been identified these were managed through patient observations and patient risk assessments.

The ward had clear lines of sight, which meant staff were able to effectively observe patients within all areas of the ward. Nurses and healthcare assistants were always within patient areas with patients. There were no call bells or alarm systems around the ward or in patient bedrooms. Staff carried out observations in line with patients' assessed needs and the organisation's policy.

There were no seclusion facilities on the ward and seclusion was not used. If a patient was to require seclusion, they were transferred to another ward. We saw one example of where this had occurred within the past 12 months.

The ward had a well-equipped clinic room. There was emergency resuscitation equipment and emergency lifesaving medication. Equipment and medication was checked on a weekly basis to ensure it was fit for use.

Safe staffing

The trust provided us with the following information about staffing levels on wards for people with learning disabilities or autism:

Total number of substantive staff 20

Total number of substantive staff leavers in the last 12 months 4

Total % vacancies overall (excluding seconded staff) 9

Total % permanent staff sickness overall 14

Establishment levels qualified nurses (WTE) 11

Establishment levels nursing assistants (WTE) 11

Number of WTE vacancies qualified nurses 4

Number of WTE vacancies nursing assistants 4

Shifts* filled by bank or agency staff to cover sickness, absence or vacancies 2

Shifts* NOT filled by bank or agency staff where there is sickness, absence or vacancies 1

The ward used a dependency tool to assess the number of staff required to ensure the safety and well-being of patients. The agreed staffing establishment had been assessed as one nurse and four support workers on each shift. The rotas we looked at confirmed this.

Staff told us there was a high use of agency staff but this was not relected in the data we were provided with prior to the inspection. During the inspection and shifts were covered by agency staff. We spoke with three members of agency staff during the inspection who were able to inform

Requires improvement

Are services safe?

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

us of their induction to the ward and the information they had been provided. The ward had booked the same staff in order to provide consistency to patients and to develop therapeutic relationships.

One agency nurse we spoke with told us she worked three days in a row and always knew in advance when they were working. They also told us that prior to commencing work in the service they could work three days supernumerary to learn about the patients and ward. However, one support worker told us they were not given the opportunity to work supernumerary, but they did work alongside experienced staff to ensure they understood the needs of each patient.

Where a patient's needs had increased staffing levels were adjusted to meet these needs. The ward manager was always supernumerary and the deputy manager was supernumerary with the exception of one shift where they were the nurse in charge. Where staff required support both the manager and deputy manager supported staff in delivering care. We observed this throughout the whole of the inspection, and this was reflected by the information provided by the staff.

Patients told us they were able to spend one to one time with staff. We observed staff talking with patients on an individual basis during the inspection and supporting them with accessing the hospital grounds for personal shopping. There was no set procedure for ensuring patients received one to one time and patient records did not always record where patients had received one to one time.

The average mandatory training rate was 71%. This was below the trusts' expectations of 80% compliance.

The ward was aware that improvements to mandatory training were required and had commenced individual plans for staff that were not meeting the expectations of training. We saw two examples of the plans in progress to ensure targets were achieved.

Assessing and managing risk to patients and staff

In the six months leading up to our inspection, there was 198 incidents of restraints. Of these 198 incidents, 12 were in the prone position. Prone restraint is where a person is held face down. The Department of Health guidance Positive and Proactive Care: reducing the need for restrictive interventions April 2014 states prone restraint should not be used.

We spoke with managers within the service and asked what plans were in place to reduce physical interventions and restrictive practice. Senior managers confirmed there were no documented plans and nobody was able to verbally explain what the service had in place to reduce restrictive practice. This is strongly advised as in accordance with the The Department of health guidance Positive and Proactive Care: reducing the need for restrictive interventions April 2014

The trust uses the Functional Analysis of Care Environments (FACE) risk assessment tool. This is a recognised risk assessment tool for assessing risks in patients with learning disabilities. Each patient had a risk assessment contained within their care records. We reviewed the assessments for all four patients and found they were comprehensive and detailed, highlighting risks such as self-harm, harm to others and sexual behaviour.

The multi-disciplinary team following an initial assessment by nursing staff agreed risks. National Institute of Health and Care Excellence (NICE) (Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges) recommends that organisations should consider using a formal rating scale such as Aberrant Behaviour Checklist or Adaptive Behaviour Scale. This would provide baseline levels for patients behaviour and a scale such as the Functional Analysis Screening Tool to help understand its function. The service did not always use these tools as part of their initial assessment although patients presented with behaviours that challenge and had complex needs. However, at the time of our inspection the service had begun to develop it's strategy on a designing a challenging behaviour pathway. This was still in it's infancy.

The service managed medicines correctly. The drug cupboard was suitable for the number of patients present and medicines were stored away safely and correctly.

We reviewed all the medication charts, they were legally compliant, legible and in accordance with the Human Medicines Regulation Act 2012. No missed signatures were noted by nurses administration in the medication records.

Nurses completed medicines management audits on a monthly basis. The service did engage in Prescribing Observatory for Mental Health UK (POMH-UK) audit. The POMH-UK aims to help **specialist mental health trusts or healthcare organisations** improve their prescribing

Requires improvement

Are services safe?

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

practice. POMH-UK, with its member organisations, identifies specific topics within mental health prescribing and develops audit-based quality improvement programmes.

Staff told us that a pharmacist visited the service weekly and did not participate in multi-disciplinary team meetings. If patients wanted to discuss medication, they would do so with the nurses or doctor. The pharmacist did not leave any audits of the medication for ward staff. Senior ward staff told us they were given verbal feedback on any errors but there was no formal process for obtaining quality feedback.

Staff were able to explain the safeguarding procedure to us. This was reported via the safeguarding leads and staff were able to tell us the name of the contact person in the safeguarding unit. Staff were able to give us examples of incidents that had been previously reported to safeguarding teams. There were no open safeguarding referrals at the time of our inspection but the ward had raised five concerns within the past six months prior to inspection. Compliance for safeguarding training was 80% this was below the trust standard of 90%.

Track record on safety

There was one serious incident reported by the ward in the twelve months leading up to our inspection.

Reporting incidents and learning from when things go wrong

There was an electronic incident reporting system in place. We spoke with two staff that were able to tell us how this worked and how they would access it to create an incident report. We looked at Ten incident records to examine how incidents had been reported. We found they were detailed and contained sufficient information to explain the events of the incident and how staff responded.

Ward staff told us there was no system in place to analyse the incidents that occurred on the ward to enable staff to proactively learn from themes and trends. Staff on the ward told us they received a breakdown of each incident from the risk team within the trust every three months but this did not provide any data that would support the service to improve. There was no evidence that debriefs happened following incidents and staff we spoke with told us this did not occur. The Trust was able to provide us with data demonstrating how incidents were analysed and that there was a review of the service following the audit. However, this was not presented during the inspection.

The 11staff we spoke with told there was no formal process for learning from incidents such as reflective practice. Staff told us they took opportunities during handover to discuss any concerns or areas for improvement and team meetings. However, there were no minutes of the team meetings for us to review, as they had not been written at the time of the inspection.

Two staff we spoke with were able to tell us the organisation's policy on duty of candour. Staff were able to provide us with an example of where an incident had occurred and the responsibilities of the organisation under duty of candour had to be implemented.

Are services effective?

Inadequate

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

Our findings

Assessment of needs and planning of care

We reviewed the care records of all four patients accommodated and found assessments were not comprehensive, holistic or person- centred. There was no, functional assessments, sensory assessments, activity of daily living assessment, use of applied behaviour analysis and limited communication assessments,

The service did present us with a formulation plan for each patient on the ward, which showed in detail how the service had considered what may have lead to deterioration in the patients mental health. The formulation plans were detailed and comprensive.

Patients did have health action plans and physical health care checks. Where patients were prescribed routine antipsychotic medication relevant checks had been carried out. For example, patients had electrocardiography (ECG) tests that was in accordance with Maudsley prescribing guidelines 2014. We also noted that blood tests had been done.

Evidence of weight monitoring and blood pressure were present and these were regularly being completed. It is encouraged that side effects of medication are discussed with patients and tools are used to capture this information. There was no evidence this occurred and equally care plans did not contain any details regarding the side effects of medication and what nursing staff are required to observe.

Care plans were written in detail where patients required medication on an "as and when required basis". Medication used for rapid tranquilisation was not reviewed for all patients. The service was not following the NICE guidelines (NG10) Violence and Aggression point 1.3.11. Evidence was present in the multi-disciplinary team notes that "as and when required" medication had not been reviewed by the patients doctor. Medication for rapid tranquilisation had not been utilised by some patients but was still present on drug cards. Where medication was not used, it had not been reviewed or stopped where appropriate.

The four care plans we looked at did not have a treatment plan or discharge plan:

- Positive behaviour support plans of each patient did not contain information that is pertinent to the principles of positive behaviour support. Details of patients' communication styles, sensory needs and specific behaviours and triggers were not incorporated within individual plans as well as details of how staff were to manage challenging and complex needs. Plans were written in a format which was reactive to patient behaviour with no preventative aspects. Staff had not received training in positive behaviour support.
- There was limited assessments and planning of communication needs across the ward. Where patients had communication assessments in place staff did not follow the plans and support patients effectively.
- A patient with autism and no verbal communication had no communication plan in place
- Patients did not have any care or treatment plans in place addressing sexual behaviour and relationships even though some patients had identified needs in this area.

One patient had engaged in cognitive behavioural therapy. The strategies that had been developed were not incorporated into any care plan and there was no ongoing support to maintain positive behaviours. Staff could not evidence how the cognitive behaviour therapy was being used to support the patient in their care and treatment.

Best practice in treatment and care

The service did not always follow best practice and guidance with regards to the care and treatment being provided on the ward.

The Department of Health Guidance Positive and Proactive Care: reducing the need for restrictive interventions sets out what the expectations are for caring and managing people who have complex needs. The service did not incorporate some elements of the guidance.

The NICE Guideline in relation to Autism is directly relevant to the services provided at Edenwood ward and this was not embedded within the service. No audits had been carried out against the Autism Diagnosis and Management Guidance June 2012.

No patients were prescribed medication over the British National Formulary guidance. The service did require some improvements to ensure that "as and when required" medication was reviewed. The service did not take into account National Institute of Health and Care Excellence: Violence and aggression short- term management in

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mental health, health and community settings May 2015 (1.2.16) and (1.3.11) and National Institute of Health and Care Excellence: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities who behaviour challenges. May 2015.

The service did not have a plan in place for reducing restrictive practice as in accordance with the Positive and Proactive Care Guidance April 2014. The service did not fully assess the communication needs of patients.

The staff on the ward were not involved in clinical audits and there were no tools in place to routinely measure outcomes for patients. Senior managers said outcomes were measured by assessing patient engagement within activities. However, the service did use Health of the Nation Outcome Scales for People with Learning Disabilities, Health Equality Framework.

Each patient had a health action plan and patients received care to ensure their physical needs were met. We saw examples of where patients had accessed the dentist for oral treatment.

Skilled staff to deliver care

There were registered learning disability nurses and healthcare support workers, a consultant psychiatrist who specialises in learning disabilities, a psychologist and assistant psychologist.

The ward manager was proactive in recruiting to nursing posts and told us that they were awaiting checks and references for one new nurse. However, there had been a vacancy for an occupational therapist for over two years which had not been filled and no recruitment strategy was in place to ensure this was done. The service received no occupational therapy support.

Staff had limited understanding of any models of care in regards to occupational therapy and equally had limited understanding of assessing communication needs, functional analysis, sensory integration, formulation and positive behaviour support. Staff told us they had not received specialist training in relation to their roles but always acted to ensure patients received the highest standards of care they were able to deliver. The trust did provide us with some information which showed that staff had received additional training in areas such as autism and makaton (a form of sign language). There was also a programme in place for other proposed training which the trust had identified as necessary for the staff working on Edenwood.

There were quarterly team meetings. We asked to review the previous meeting minutes but these were not available despite the meeting taken place over three weeks prior to the inspection.

Non-medical staff performance appraisals was currently only at 41%for the twelve months leading up to our inspection. During our inspection we saw evidence that this was being slowly addressed. We found only three qualified staff had received supervision and appraisal. Only 11% of non-clinical staff had received an appraisal, staff had attended distance learning at university to qualify as assistant practitioners. One of these staff had taken a lead role in physical healthcare whilst another had taken a lead role in autism. Other staff we spoke with said the service did not fully support staff in career development and described relevant conferences and training not being supported.

Multi-disciplinary and inter-agency team work

There were multi-disciplinary meetings on the ward each Tuesday. This included the nurses, support staff, doctors, and psychologists and commissioners. The meetings discussed the current care and treatment of the patient and their progress to finding alternative placements. We observed two multi-disciplinary meetings during the inspection and found they were well structured, discussed patients' mental capacity and future placements for patients.

However, the records of multi-disciplinary notes were poor as they were often not documented in patient care records.

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

Training data on October 2015 showed that 37% of staff had received Mental Health Act 1983 (MHA) training. This was below the trust target of 80%. However, staff on the ward showed a good understanding of the MHA.

We looked at the care records of two people who were detained under the MHA and found good recording of detention under the MHA. This included section 132

Are services effective?

Inadequate

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.

informing people of their rights monthly for patients detained on a section 3. It was unclear how this was completed where patients had no verbal communication and limited ability to communicate their needs to staff.

We saw evidence on the ward of posters to explain information about patient rights under the MHA and how to contact the Care Quality Commission to make a complaint. However, these were displayed in an area which patients did not have access too.

Patients had a certificate of consent to treatment (T2) or certificate of second opinion (T3) in place to authorise their medical treatment and these were attached to the medication charts. The recording of capacity and consent to treatment was recorded in all patients' records.

Independent Mental Health Advocates (IMHA) were available. Two patients told us how they contacted the IMHA should they require advocacy support.

Good practice in applying the Mental Capacity Act

We looked at the care records of all patients. Some patients had limited communication and some were unable to verbally communicate. The service did not presume a lack of capacity due to communication difficulties. However, it was unclear how patients were being supported to be involved in their care and treatment.

A total of 95% of staff had had training in the Mental Capacity Act 2005 (MCA) at October 2015. This was meeting the trust target of 80%.

There was one patient under a deprivation of liberty safeguards authorisation.

Staff we spoke to understood the principles of the Mental Capacity Act (MCA) and were able to give us one example in relation to a patient discharge. The service had developed a number of easy read scenarios and reports assist the patient to make decisions about future care. The assessment was thorough and demonstrated that the service protected the rights of individuals.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed interactions between patients and staff that were respectful and kind. We observed incidents where a patient was distressed or anxious and found staff responded to the patient's needs with a positive and caring attitude.

Patients told us that staff were kind, caring, and helped them, and supported them to feel better. They also told us they helped them understand often very difficult discussions and gave them the time they needed to ensure they understood their care and treatment.

The staff we spoke with all knew the patients very well. Some patients had been known to the service many years and had received care as an inpatient on many occasions. Staff were able to use the knowledge they had of the patients to ensure they felt safe on the ward. One patient was able to tell us of an occasion where they did not feel safe and how staff provided them with comfort, support and reassurance.

The involvement of people in the care that they receive

On admission patients received an induction pack that contained details of the services provided and information regarding access to advocacy and their rights as a patient on the ward. The information was in easy read but this did not meet the needs of all patients who did not understand easy read material.

Care plans were not person-centred for all patients, there was little focus on increasing skill and independence. Plans had not been developed in line with how patients communicated other than some easy read templates, which was not suitable for all patients. The service told us they recognised this as an area for improvement but did not have a plan in place.

Patients and their careers were invited to multidisciplinary and care co-ordination meetings. We saw minutes of meetings where carers had been involved in decisions regarding discharge and where necessary due to a patients' mental capacity decisions regarding care and treatment.

Patients told us they attended weekly community meeting where they were able to discuss any issues or concerns they had. They also said they were able to discuss activities and menu choices. There were no outstanding actions from any of the meeting minutes.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

The average bed occupancy over the last six months was 77%. The ward had 6 beds but only four beds were occupied during the inspection. Information provided by the trust stated there were three out of area placements in the six months leading up to our inspection. In the last six months there has been no delayed discharges but two patients had been re-admitted to the service within 28 days of discharge. The service told us although there was an admission criteria patients' were sometimes admitted to the service when their needs could be met elsewhere. We were given examples of how this occurred in relation to one patient on the ward.

The average length of stay was three months. Staff working in the service told us they were proud of this because this reflected the philosophy that "hospital was not a home" and patients should be discharged as soon as possible. Staff actively worked towards an estimated discharge date detailed in patients admission records. However, none of the patients had a discharge plan in place even though some patients were close to moving to other services but the service had worked with funding authorities to develop a "person specification" identifying the needs of the patient for when they moved from hospital.

Staff told us one of the main issues patients often complain about is delays in discharge. Staff told us patients get very frustrated and upset about the length of time it can take to secure funding for future placements. Staff explained these issues were out of their control and although they worked hard to support patients, it was an issue that also frustrated the staff team. Delays in discharge often led to patients becoming distressed and anxious. During our inspection, we saw one patient become distressed and anxious due to the length of time it was taking to secure funding. Staff responded to the patient with caring attitude and explained the reasons for delay.

The facilities promote recovery, comfort, dignity and confidentiality

Patient's activity records showed they engaged in a range of activities such as going to the shops, going for walks, car rides, and other leisure activities. Activities were provided on a daily basis including weekends however these were limited in therapeutic nature as some taks such as having a bath and getting dressed were regarded as an activity.

The ward had a full range of rooms and equipment to support treatment and care. There was a clinic room to examine patients with a couch and chairs so patients could consult with the nurse or doctors in private. There was also space for patients to engage in activities as well as a kitchen patients could access to make drinks and snacks.

There were quiet areas on the ward and a room where patients could meet visitors. These were located in areas where visitors did not have to walk into main patient areas to ensure privacy and dignity. The ward scored 88% on the trusts audit for privacy and dignity.

Patients could make a phone call in private and had access to their own mobile phones and other computer equipment. This enabled them to remain in contact with friends and family outside of the hospital ward.

Patients had access to outside space when they wished. There was a small courtyard where patients could go into directly from the ward and this was a space designated specifically for those accommodated on the ward.

The food was of good quality. Patients told us they had a varied menu and were happy with the food provided. However, staff said the food quality had deteriorated since it had changed to reheat system and that quality and quantity of the food was an issue.

We looked at the bedrooms of two patients and found they were personalised. They both had pictures on the walls that they had chosen as well as other personal items.

Meeting the needs of all people who use the service

The ward was fully accessible to any patients who had mobility aids such as wheelchairs. There were walk in showers and bathrooms to ensure patients' personal care could be adequately maintained. All bedrooms were on the ground floor so they had easy access to all patients.

There were no leaflets provided in different languages to patients. Staff told us that if a patient who did not use English as their first language could access other information and an interpreter.

Care plans detailed any religious or spiritual needs patients had and where patients wished to access the hospital chaplain or any other religious statues then this was made available.

Are services responsive to people's needs?

Requires improvement

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

The service catered for patients' individual dietary requirements. Patients told us if they were vegetarian or vegan then they were provided with individual meals that met their needs and views.

Listening to and learning from concerns and complaints

There were three formal complaints made about this service from 1 November 2013 to 29 October 2015. The details of the complaints involved a patient being unhappy about their care and treatment, a complaint about delays in discharge and a complaint regarding conduct of a member of staff.

There was information displayed around the ward to explain to patients and relatives how to complain if they wanted to. There was also a patient experience team who would try to resolve issues at a ward level. Two patients we spoke to told us they were given information on admission about how to make a complaint. They also told us they would also speak with carers and advocates should they be unhappy with anything on the ward.

Staff told us that they always attempted to resolve patient issues and would use community meetings as a starting point to engage patients in anything about the service they were unhappy about.

Are services well-led?

Inadequate

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

Our findings

Vision and values

The trust values of "kindness, fairness, ambition and spirit" were displayed in staff and patient areas of the ward. Staff told us they had been involved in developing the organisation values and were able to explain the values to us.

Staff were able to tell us the names of the most senior managers in the organisation. They were disappointed that they had not visited the ward and had not recognised the service required resources in occupational therapy and speech and language therapy. Staff said they were disappointed they had not received training they had requested and felt other services received more resource allocation. Staff told us they valued their work but did not feel valued by senior managers.

The staff told us their immediate managers were approachable and easily contactable should they need to speak to them. However, staff also told us the service was chaotic and not focused. Staff said they felt stressed about receiving phone calls on days off and not receiving supervision or appraisal.

The ward staff told us that they felt supported by the clinical leadership team, however they also said having no occupational therapy or speech and language therapy made their roles more difficult. Staff told us they felt listened to and their views were important but their opinions and views were not acted upon by the wider organisation. There were no plans in place to support staff with areas such as supporting patients with occupational therapy and communication.

Good governance

Ward managers received monthly emails regarding the status of their mandatory training compliance. However, some of the information was not always correct because the internal system had not always been updated.

Appraisals were undertaken annually, at the time of our inspection the trust provided us with data that showed only 41% of staff had received an appraisal in the last year. Staff told us they should receive supervision every four weeks but this rarely occurred. Supervision records we reviewed for two staff showed that there were months between supervisions.

We reviewed audits in relation to record keeping, environmental hygiene standards, stock checks of medication and staffing levels. Mangers said they were also responsible for overviewing staff training. However, the ward manager had not developed any action plans regarding missing documentation in patient records or any strategy to address poor mandatory training, supervision or appraisal.

Staff knew how to report incidents and records were comprehensive and detailed. However there was no formal process for learning from incidents and there was no evidence of any debrief taking place with staff or patients.

The ward manager had sufficient authority to increase staffing numbers should this be required. They also attended a regional management group on a two weekly basis. The group had been operating for three weeks at the time of our inspection; however, there were no meeting minutes or action points for us to review.

There appeared litte or no strategy for the service. Many of the care practices did not relect national guidance for a service that was providing care to patients with learning disabilities in todays expectations. We requested to see the service review but this was unwritten. There were clear fundamental failings that were identified during the inspection that clearly were not identified through any robust audit system within the trust. There were no improvement plans in place and an apapranet lack of leadership both at ward and service level.

Leadership, morale and staff engagement

The sickness level for the ward at the time of our inspection was 15%. This is above the trusts average of 4.8% and above the national average of 5%.

Staff told us they were aware of the whistleblowing policy and how to report concerns should they need to. All staff we spoke to told us they were confident in raising any concerns to their managers if they had a problem but found this was not always dealt with. We were provided with an example of staffing dispute where no action had taken place.

Staff we spoke with told us they enjoyed working on the ward but described it as very challenging and because of the number of restraints being used on patients found it emotionally draining.

Are services well-led?

Inadequate

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.

Staff told us morale fluctuated on the ward and although they had a lot of respect for management, they often found management practice to be ineffective. They told us they did not feel empowered in their role to make decisions.

Commitment to quality improvement and innovation

The ward had received Accreditation for Inpatient Mental Health Services (AIMS).

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients on Edenwood did not have care plans that were person-centred, holistic or presented in a way their met their communication styles. This is a breach of regulation 9 (1)(a), (b), (c) (2) (a),(b) (c) (d) (e) (4) (5) (6)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Patients on Edenwood did not receive care in accordance with their assessed needs. Edenwood did not follow best practice and guidance in relation to supporting patients with communication difficulties and complex needs. Staff on Edenwood had not received specialist training to support them in their role to care for patients with the level of complex needs they presented. Patients on Edenwood did not have any discharge plans in place. This is a breach of regulation 12 (1) (2) (c),(i) (c) (d) (e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no effective arrangements in place for assessing the quality of the service.

This section is primarily information for the provider

Requirement notices

Patients records on Edenwood were not always up-to date. For example recording of multi-disciplinary team meeting were missing from records. Information in care records was not always updated where changes occurred.

Records relating to the management of the service were also absent such as team meeting minutes and regional meetings.

This is a breach of regulation 17 (2) (a) (b)(c) (d) (ii)