Eldertree Lodge

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Start here.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Eldertree Lodge is an independent mental health 41 bedded hospital. It provides specialist inpatient service for adults aged 18 years and over in rehabilitation units specifically for patients with a learning disability or autism.

Our rating of this service went down. We rated it as requires improvement because:

- The provider had not made sure that the environment was suitable for all patients it provided care to. Although it was providing care to adults with a learning disability and autism the wards were not 'autism friendly' in line with national recognised best practice. For example, managers had not considered the conflicting sensory needs of patients living on the same ward. Ward environments were not tailored to the sensory needs of individual patients.
- The provider had not ensured that staff received specialist training in caring for people with autism, including training in specialist communication skills.
- The provider did not ensure that the systems used to access information was well organised, staff were struggling to find essential information to support safe and effective care delivery, whether it was on electronic or within paper notes.
- Staff did not always follow best practice when storing and dispensing medication. Staff on Maple Ward did not routinely record the date of opening of new creams and bottles. They therefore could not be assureds the medications were still effective when given to patients. The providers own audits of medicines management had not identified the error we found on inspection.
- Staff supervision was not managed well; managers did not have robust systems to ensure they knew whether staff received regular supervision.

However:

- The service generally provided safe care. The ward environments were safe. The wards had enough nurses and doctors. Staff assessed and managed risk well, followed good practice with respect to safeguarding and minimised the use of restrictive practices.
- Staff implemented good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging. The service had identified a local theme in self-harm through swallowing batteries and provided an individualised response to patient risk.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. The multidisciplinary team involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Patients led discussions of their experience of care in a programme of 'noise, voice, choice' meetings. Carers, families and external agencies were extremely positive about the service and believed the service always managed challenging behaviour well.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. The provider had developed some local accommodation options that the hospital clinical team could continue to provide some support to patients as they settled in and got to know a new staff group. Staff helped patients with advocacy, cultural and spiritual support.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Requires improvement

Eldertree Lodge

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

Summary of this inspection

Background to Eldertree Lodge

Eldertree Lodge is an independent mental health hospital provided by Huntercombe (Granby One) Limited. It is a 41 bedded hospital providing specialist inpatient service for adults aged 18 years and over in locked rehabilitation wards specifically for patients with a learning disability or autism. Patients may present with a range of behaviours that are challenging, mental health problems, drug and alcohol abuse. Patients may be detained under the Mental Health Act 1983 or subject to Deprivation of Liberty Safeguards. All treatment programmes are delivered through a multidisciplinary team approach. The service is commissioned by clinical commissioning groups. Eldertree Lodge has a registered manager and is registered to provide the following regulated activities:

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

• treatment of disease, disorder or injury.

• diagnostic and screening procedures.

Since the last inspection the hospital has decommissioned all secure beds and changed its name from Ashley House to Eldertree Lodge, also changing all the ward names. Eldertree Lodge is located in the outskirts of a rural village between Market Drayton and Newcastle-under-Lyme. The hospital has six wards that comprise of three admission and three discharge units:

Admission wards:

• Elm ward, seven beds, high functioning male only

• Chestnut ward, six beds low functioning male only

• Ash ward, six beds, complex care female only.

Discharge units are:

• Maple ward, seven beds, low functioning male only

• Birch ward, eight beds, high functioning male only

• Willow ward, seven beds, complex care female only.

The Care Quality Commission last carried out a comprehensive inspection for this hospital in September 2017, we rated it as good overall. We rated safe, effective, caring, and well-led as good. Responsive was rated as requires improvement and we issued the following requirement notice: Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and respect:

The hospital did not ensure that a patient was placed in an environment in which their privacy and dignity were always respected. There was no clear long term plan in place to ensure that the privacy and dignity needs of the patient would be appropriately met in the future.

At this inspection we found that the provider had taken actions to make improvements but we have identified breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for:

- Regulation 17 good governance
- Regulation 18 staffing

In the last two years all wards had been visited by our Mental Health Act Reviewers. There were 33 patients in the hospital when we inspected, all patients were detained under a section of the Mental Health Act. There were no informal patients, or patients subject to Deprivation of Liberty Safeguards (where a person's freedom is restricted in their best interests to ensure they receive essential care and treatment).

Our inspection team

The team that inspected the service comprised four CQC inspectors, an inspection manager and a variety of specialist advisors: one consultant psychiatrist in learning disabilities, one nurse with specialist in learning disabilities, one speech and language therapist in learning disabilities and one expert by experience who had experience of using learning disabilities services with support from a carer.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our ongoing programme of inspections.

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 the location, asked a range of other organisations for information and sought feedback from patients and carers through comment cards.

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 13 patients who were using the service;
- spoke with two carers/family of patients who were using the service;
- spoke with the registered manager and service managers for each of the wards;
- spoke with 27, other staff members; including doctors, nurses, occupational therapist, psychologist, social worker, speech and language therapist, activity workers, human resources advisor, and mental health act administration;
- received feedback about the service from three care co-ordinators or commissioners;
- spoke with two independent advocates;
- looked at the provider's records for 15 staff (permanent, bank and agency);
- attended and observed the pre – discharge multidisciplinary meeting, restrictive practice group, hand-over, and multi-disciplinary morning meeting;
- collected feedback from nine patients and carers using comment cards;
- looked at 24 care and treatment records of patients;
- carried out a specific check of the medication management on all wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 13 patients across the hospital and all fed back positively about staff and how they were treated. Most patients told us they had discussed their discharge plans. Four patients said that what they liked most about the service was that they were able to visit their families. Most patients said that staff supported and treated them well with dignity and respect and behaved kindly. Patients told us staff were never too busy to spend time with them. Some patients said that what they liked was that there had been improvements to the activities and group work particularly around weekends and evenings.

We obtained feedback from nine carers and relatives via comment cards and spoke to two carers. The majority said they felt staff listened to their concerns, were polite, courteous, pleasant and respectful. There were good relationships with staff and patients and that staff were committed. One carer reported that previously the hospital had not kept them updated but this had improved and they now kept updated, involved in the multi-disciplinary team meetings and they could input into plans for discharge. They felt the hospital was safe, supported family visits and it planned discharge well. They said their loved ones were happy at the hospital.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to keep people safe from avoidable harm and abuse. Most staff were up-to-date with mandatory training. There were vacancies within the hospital that was being managed well by the manager. There was appropriate use of bank and agency staff to cover vacancies and staff absence. This was an improvement since our previous inspection.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. This was an improvement since our previous inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had the skills required to develop and implement good positive behaviour support plans.
- Staff carried out observations on patients in line with policy and recorded these at the time of the observation.
- Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the stop over-medicating people with learning disabilities programme (STOMP).
- Staff and patients took part in the 'Safewards' model, which emphasises better relationships between staff and patients and increases patient safety. Staff used tools like the soft words.

However:

- Electronic and paper records were not appropriately organised and fully integrated together. Staff could not easily locate documentation as they were saved in different areas. This meant that staff could miss key information and staff may not always have all the information they needed at hand.
- Staff had not always followed best practice when storing and dispensing medication. Staff on Maple did not always follow

Summary of this inspection

systems and processes to safely store and manage medicines, staff did not routinely record the date of opening of new creams and bottles therefore could not assure they were still effective when given to patients.

Are services effective?

Requires improvement

Our rating of this service went down. We rated it as requires improvement because:

- Staff supervision was not consistently carried out in a structured way that captured areas of discussions; it varied in detail and quality. There was no clear evidence on how staff were supported with opportunities to update and further develop their skills. This had not improved since the last inspection.
- Managers did not always ensure that staff had the further specialist training to work with complex autism. Staff had not received any ongoing specialist autism training that effectively met the complex needs of patients with autism.
- The service did not ensure that the needs of a patient with specific communication needs were met.

However:

- Patients had access to psychological therapies, to support for self-care and the development of everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes.
- Staff from different disciplines worked together as a team to benefit patients. The wards had access to a full range of specialists required to meet the needs of patients on the wards. Managers provided an induction programme for new staff.
- The wards had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- Staff assessed the physical and mental health of all patients on admission. They worked with patients and their families to develop individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff understood their roles and responsibilities under the Mental Health Act 1983, the Mental Health Act Code of Practice and the Mental Capacity Act. Managers made sure that staff

Summary of this inspection

could explain patients' rights to them in a way they could understand. Staff assessed and recorded capacity clearly for patients who might have impaired mental capacity. We saw evidence of best interest meetings having taken place.

Are services caring?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback from community meetings on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately and they were confident their relatives received great care and treatment in a safe environment. Carers, families and external agencies were extremely positive about the service and believed the service always managed challenging behaviour well.

Are services responsive?

Good

Our rating of this service improved. We rated it as good because:

- Patients had access to a wide range of meaningful activities on the wards and in the community, throughout the weekdays, during the evenings and weekends. This was an improvement since our previous inspection.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- Staff helped patients with advocacy and cultural and spiritual support.
- When patients complained or raised concerns, they received feedback.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

Summary of this inspection

- The environment was not autism friendly, the provider had not carried out an autism friendly assessment to ensure that the environment was therapeutic for patients with autism.
- There was one sensory room onsite in one ward were other patients did not have easy access to, which was inadequate to cater for the needs of all patients in the hospital who would benefit.

Are services well-led?

Requires improvement

Our rating of this service went down. We rated it as requires improvement because:

- The provider had not made sure that the environment was suitable for all patients it provided care to. Although it was providing care to adults with a learning disability and autism the wards were not 'autism friendly' in line with national recognised best practice.
- The provider had not ensured that staff received specialist training in caring for people with autism, including training in specialist communication skills. There was no in-depth specialist training offered for autism or the specialist communication skills to address needs of patients.
- There was a lack of effective oversight on several operational governance processes.
- Senior managers had not sought assurance that supervision was carried out consistently and the systems to monitor incidents were not fully embedded.
- There was insufficient oversight of the governance process for ensuring that the investigations process for incidents were always completed thoroughly. Whilst incidents had been investigated staff had not closed them down on the system and some still needed a senior member of staff's signature to indicate they had been closed.
- The provider did not ensure that the systems used to access information was well organised, staff were struggling to find essential information to support safe and effective care delivery, whether it was on electronic or within paper notes.

However:

- The provider had made the improvements to improve its staffing. It had ensured there were appropriate strategies for recruitment and retention of the workforce that included flexible working and increase in support workers rates.
- Leaders were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Summary of this inspection

- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Training records indicated that 97% of staff had received training in the Mental Health Act. Staff showed a good understanding of the Mental Health Act and the code of practice.

Records of detained patients were up to date, stored appropriately and compliant with the Mental Health Act and the code of practice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Consent to treatment and capacity forms were appropriately completed and attached to the medication charts of detained patients.

Wards displayed information on the rights of detained patients where it was easily accessible. The independent mental health advocacy services were readily available to support patients.

Staff routinely explained to patients about their rights and monitored this regularly. Staff repeated the rights at regular intervals if patients had difficulty understanding the information given. They used easy read information forms.

Staff knew how to contact the Mental Health Act administrator for advice when needed. There was a hospital Mental Health Act administrator and a corporate Mental Health Act department.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that 86% of staff had received training in Mental Capacity Act. Staff spoken with demonstrated a good understanding of Mental Capacity Act and they could explain the five principles.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. The service monitored how well it followed to the Mental Capacity Act and acted when they needed to make changes to improve.

None of the patients were subject to Deprivation of Liberty Safeguards. There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff conducted capacity assessments for each patient at the time of admission. The capacity of individual patients was discussed on a decision specific basis at multi-disciplinary meetings and ward round meetings.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients recognising the importance of their wishes, feelings, culture and history.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Notes

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Good

Safe and clean care environments

Safety of the ward layout

Staff completed and regularly updated risk assessments of all ward areas and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The provider carried out an environmental ligature risk assessment which identified these ligature points. The wards had risk management plans on how to minimise ligature risks to patients but the plans did not clearly document instructions for staff on how to manage some of the identified risks. The wards had ligature cutters available in nurses' offices. Staff were trained on how to use them and knew where they were kept.

The fire alarm was tested each week. Fire safety equipment had been checked and maintained. Different wards carried out fire drills and an evacuation of the ward on a weekly basis.

Staff could observe all parts of the wards in Ash and Chestnut only. All other wards were spread across two floors and mirrors were used to mitigate any risks within blind spots in Birch and Elm. The mirrors located on the stairs in Maple ward were not enough to allow adequate observation of the blind spots, and there were no mirrors located on the stairs in Willow ward. Bedrooms were located upstairs along one corridor which made it easy for staff to observe. We were told that there were always staff located on the bedroom corridors at night to maintain observations. The hospital had taken appropriate steps to mitigate the risks associated with blind spots by installing closed-circuit television (CCTV) in communal areas and staff could access recordings when needed.

All bedroom and bathroom doors had anti-barricade locks and staff knew how to unlock them. Staff told us they held anti barricade drills weekly.

There was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff used different code protocols (red and blue) to respond to either a medical emergency or assistance with violence and aggression. Staff who were assigned to respond had adequate training.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose apart from Chestnut, where the level of cleanliness was poor. Although cleaning records were up to date and showed all parts of the wards had been cleaned, floors in the dining room looked dirty and there were old drink stains on skirting boards in the kitchen.

Staff followed infection control policy, including handwashing. The hospital's practice nurse was the identified lead for infection prevention and control. Wards carried out monthly audits of infection control and prevention. The managers took action to address any improvements needed.

Seclusion room

The seclusion room met all the requirements of the Mental Health Act Code of Practice. It allowed clear observation and two-way communication.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment, such as automated external defibrillators, oxygen cylinders and emergency drugs. Staff checked emergency equipment and medicines regularly to ensure that it was safe to use when needed. The resuscitation grab bags were sealed with a tamper-evident seal to ensure the contents of the bag remained secure and available. The hospital carried out monthly drills to check that staff were able to respond on time in an emergency. Staff told us, as part of learning from an incident, to ensure a timely response, the drills had been increased to twice a month.

Staff checked, maintained equipment well and kept it clean on all wards apart from, Willow clinic room where cupboard tops were dusty. We highlighted this with staff at the time of inspection who immediately addressed this.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The hospital established its staffing levels in line with the National Institute for Health and Care Excellence (NICE) guideline SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals. They took into account the bed occupancy, the acuity and risks of their patients to ensure that they met patients' nursing needs safely. Patients told us that there were enough staff on the wards.

The wards had multiple nursing vacancies, there were 14.4 (48%) registered nursing vacancies and 47.9 (40%) support worker vacancies at the time of inspection out of a whole time establishment of 30 nurses and 120 support workers. Although there had been an improvement on recruitment of staff since the last inspection, we found that there was still a high use of agency staff. However, the organisation had taken some steps to drive recruitment and this was still work in progress. We saw that they had a detailed strategy for recruitment and retention of the workforce that included flexible working. The hospital held weekly recruitment campaigns. These were taking place at the time of the inspection. There were enough staff to provide safe care for the patients on each shift. Vacancies were filled by bank and agency staff, who were familiar with the service. Managers mitigated the risks associated with high use of agency staff by contracting agency staff on long term contracts and including them as part of the established team. This ensured that consistency and continuity of care was maintained as best as possible. All agency staff received the same intensive corporate induction and supervision as permanent staff. They had the same clinical responsibilities and understood the service before starting their shift. Some of the agency nurses on long term contracts had been with the hospital for more than two years. Most patients told us the agency staff were familiar to them and they had a good relationship with them. At times they could not tell who was an agency member of staff and who was permanent. New agency and bank staff were required to complete an induction checklist before starting on the wards. The hospital director told us that until they managed to recruit all the staff they needed, employing block booked agency staff was the best way of maintaining consistency.

Staff said there had been a recent period when there had been a high level of patients requiring constant observations with a high volume of incidents of violence and aggression, which had a negative impact on staff morale. Managers told us, in response they had increased and continued to review the staffing levels on a daily basis to ensure patients and staff were safe.

At the time of the inspection, the whole time equivalent staffing for each ward was: 25 (five nurses and 20 support workers). The vacancies at the time of inspection were as follows: Ash: 3.8 nurses and 7.3 support workers, Birch: 1.7 nurses and 8.13 support workers, Chestnut: 3.5 nurses and 9.1 support workers, Elm: 2.8 nurses and 8.9 support workers, Maple: -0.6 nurses and 7.9 support workers and Willow: 3.1 nurses and 6.5 support workers.

The hospital had three service managers that worked 9am to 5pm who were based on the wards and were not included in the shift staffing numbers. We were told that where shifts could not be filled as a result of sickness and absence, managers would step in to cover the shifts.

There were 3371 shifts filled by agency staff in the three-month period from July 2019 to October 2019 and these included use of enhanced observations. There were 76 shifts that had not been filled by bank or agency staff, as result of staff sickness or absence in the same period.

The sickness rate in the 12-month period from October 2018 to September 2019 was 5.4% for nurses and support workers.

The staff turnover rate for, October 2018 to September 2019, was seven for nurses and 34 for support workers. During the same period the hospital had 13 nurses and 35 support workers as new starters.

Patients had regular one to one sessions with their named or allocated nurse.

Staff shortages rarely resulted in staff cancelling escorted leave. However, one patient and some staff we spoke to said offsite activities would sometimes be rearranged due to lack of drivers on the shift.

At the time of inspection, the hospital had 14 patients on enhanced observations, ranging from 1:1 to 2:1 at all times. We observed an improvement since the last inspection on how staff were carrying out close observations. Staff were actively engaging with patients in activities whilst carrying out close observations.

The service had enough staff on each shift to carry out any physical interventions safely. Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There were doctors on site weekdays 9am to 5pm. The hospital had an out-of-hours doctor on call system that ensured a doctor could get on site quickly if needed.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Eighty-six per cent of staff had completed mandatory training. The hospital provided mandatory and essential training to staff. The hospital had 25 areas of training identified as mandatory training. This included immediate life support, basic life support, the Mental Health Act, the Mental Capacity Act, safeguarding adults and children, medicines management, fire safety, positive behaviour support, prevent radicalisation and managing violence and aggression. In the previous inspection there were nine areas that were below 75%. On this inspection, we found an improvement and that 23 areas of training had been 75% or above. The following areas were still below 75%; managing medications 53% and fire safety 72%.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We looked at 24 care records of patients and found that each of these contained a risk assessment. Staff completed risk assessments for each patient on admission using a recognised tool. They used different, but relevant, tools depending on the needs of the patient and reviewed this regularly, including after any incident. All risk assessments were up to date with changes shown when risk changed.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Each patient had a detailed positive behaviour support plan that clearly showed a good understanding of why their behaviours happened and considered the person as a whole in determining ways to safely support patients. Staff understood patients' positive behavioural support plans and provided the identified care and support. Psychological formulations and assessments informed them.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff were aware of patients' presentation such as early warning signs, triggers and ways of intervening that included teaching new skills.

Staff followed procedures to minimise risks where they could not easily observe patients.

The service did not have blanket restrictions approach to care and treatment. Staff individually risk assessed patients according to their level of ability and risk posed.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff recorded the reasons for carrying out searches ensuring that the decision and methods used to search were proportionate to the risks. Staff rarely conducted searches on patients and they were only carried out where the risk was deemed high.

Patients were encouraged to stop smoking and staff offered nicotine replacement therapies to assist them with this. The hospital planned to become smoke-free and staff were working with patients to help them prepare for this.

The hospital had no informal patients admitted at the time of the inspection.

Use of restrictive interventions

On this inspection, the service had improved in monitoring levels of restrictive interventions. Staff used British Institute of Learning Disabilities (BILD) certified restrictive interventions (which was a requirement to be enforced fro**m April 2020,** for all NHS commissioned services and the Care Quality Commission that only BILD Certified restrictive intervention training can be delivered in services supporting people with autism, learning disabilities in England.) Managers reported that these were well embedded and could evidence how they had reduced their floor restraints. We observed a reducing restrictive practice meeting where staff were being encouraged to be more proactive. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff devised plans to manage behaviours that challenged. Staff used the 'Safewards' model to reduce the risk of the use of restrictive interventions. Staff told us how they tried to establish a rapport with patients and talked to them using "soft words" when they were distressed with the aim of reducing the need for restraint.

This service had 1361 incidences of restraint (involving 47 different service users) between June 2019 and October 2019. This was lower than the 2074 incidences reported in the previous inspection in a six-month period from February 2017 to July 2017. Staff reported the use of restraint through the incident reporting system. Overall, there was a high level of reporting of all levels of restraints and staff recorded any hands-on interventions as restraint. They told us that the multi-disciplinary team reviewed all incidents of restraint and that most were for self-harming behaviour.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Records showed that staff only restrained a patient because it was necessary to prevent harm to the patient. Patients we spoke to said staff used restraint appropriately and as a proportionate response to prevent harm.

The provider trained staff in physical interventions and ensured that all agency staff had the same training and they were aware of the techniques required. Staff told us some of the agency staff had been trained in Management of Actual or Potential Aggression (MAPA). However, the hospital used different approved managing violence and aggression techniques. To ensure patient safety the hospital had started to roll out training of the approved training to agency staff. The hospital shift coordinator would assess at the start of each shift how many staff were trained in the approved techniques and ensure the staff with the appropriate training would be assigned to respond to emergencies. They would also ensure that the staff would be appropriately distributed within the wards taking this in consideration.

There had been no incidents of rapid tranquilisation over the reporting period. The service understood rapid tranquilisation as the use of medication by the intramuscular route as stated in National Institute for Health and Care Excellence (NG10). When required oral medication was used as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression. It was not used often.

Seclusion

There had been 51 instances of seclusion over 12 months up to October 2019. When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff kept records for seclusion in an

appropriate manner. We found evidence that the provider monitored and audited the seclusion records, with clear evidence of lessons learnt and action plans that staff adhered to.

Segregation

There had been three instances of long-term segregation over the 12-month period up to October 2019. At the time of the inspection there were two patients being cared for in long-term segregation. Both were ready for discharge with bespoke packages of care in place. Staff completed daily, weekly and monthly reviews and we did not find any gaps in recording. Staff followed best practice, including guidance in the Mental Capacity Act Code of Practice, if a patient was put in long-term segregation and recording as per the long-term segregation protocols. The quality of reviews was good. All staff working with these patients demonstrated good knowledge of the patients they were observing, their risks and what level of observations they should be on. These patients could mix with other patients and this was well care planned.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training that was appropriate to their role, on how to recognise and report abuse. Staff kept up-to-date with their safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff made safeguarding referrals when patients were cared for in long term seclusion.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

The service made 177 safeguarding referrals between December 2018 to December 2019. Most of these were for patient to patient verbal threats/intimidation or physical aggression. The number of safeguarding referrals reported during this inspection was lower than the 299 reported at the last inspection. The hospital had no serious case reviews commenced or published in the last 12 months from September 2018 to September 2019.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There were three incidents where staff reported inappropriate use of restraint by other staff and the managers took appropriate action against the staff members involved.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. On Birch ward, there were posters on “Show racism the red card” as a permanent reminder for staff and patients’ against harassment and discrimination.

The social work team clarified any safeguarding risks in relation to the patient’s family or children and ensured that these were considered by the multidisciplinary team when planning home or community leave. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed the providers policy for children visiting the hospital to ensure safety. Patients’ contact with children was planned in advance and subject to a risk assessment. Staff discussed and risk assessed visits from children considering any child protection issues. There were meeting rooms away from the wards where visiting children could meet with patients safely.

Staff access to essential information

Staff did not have easy access to clinical information.

The wards used both paper and electronic systems. On this inspection, we found that records were not appropriately organised. Whilst information was stored securely, staff could not easily locate documents as they were saved in three different areas, paper records, shared drive and patient information system. We had identified this as an area requiring improvement at our last inspection in September 2017, as records were not appropriately organised and fully integrated. Managers had since created an index within the paper records to help staff locate documents. However, during the inspection, not all staff could easily locate documents as they were saved in different areas. Some staff including the bank and agency staff told us it was confusing to locate documents as they

were not always saved in the same place. The electronic system did not allow some of the documents to be created through the system and were either kept in paper format or on the shared drive. Some of the documents were scanned onto the system and some were not therefore causing confusion where to find it. The information was available for staff but it was difficult to clearly find all the information needed for each patient. Managers told us there were plans in the company to upgrade the system used.

Medicines management

The service used systems and processes to safely prescribe medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of stopping over-medication of people with a learning disability, autism or both (STOMP). However, the date of opening or preparation were not always added to medicines where this reduced the expiry date and mental health act documentation was not always with the correct prescription chart.

The wards had appropriate arrangements for the management of medicines. Medicines were stored securely in a locked clinic room and cabinet. The clinic rooms were very small apart from those on Maple and Willow. Staff recorded fridge and room temperatures daily to ensure that they were always kept within safe range.

An independent pharmacist carried out the weekly audits. Staff generally followed good practice in the prescribing and administering of medicines, for example on Maple staff, including agency support workers were trained in the administration of buccal midazolam.

The local pharmacist also conducted a weekly visit to monitor the safe management of medicines, check medicines stock and administration. However, improvements were required in the recording and storing of medicines on Maple ward. Staff were not following guidelines on recording when they opened medications where the medicines have a reduced in-use expiry date. For example, one product was licensed for up to eight weeks use following reconstitution. However, the staff had not recorded either the date of preparation or the revised in-use expiry date and therefore would not know when the new expiry date was and when the product would become ineffective. Staff had not picked up this issue from their own internal audits and monitoring.

We looked at their recent medicine management meeting minutes and managers had highlighted that 50% of actions on Chestnut had not been responded to. On inspection, we found staff had failed to identify other possible errors on prescription cards on Birch ward. One prescription card stated the patient had a T3 yet there was a valid T2 attached and another had the wrong ward name on it, despite the patient being there for the past year.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service worked towards achieving the aims of STOMP (Stopping Over-Medication of People with a learning disability, autism or both). Stop Over-Medicating People is a national improvement programme to help people to stay well and have a good quality of life. It focuses on ensuring patients work with staff and the people who support them to get the right care and treatment, have regular medicine reviews, make sure they are taking the right medication for the right reasons, and find other ways for patients to stay well. Staff knew about and applied Stop Over-Medicating People procedures to help reduce the use of 'when required' medication.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Health and Care Excellence guidance. Health checks were carried as required for those patients on antipsychotic medicines.

Track record on safety

The service had a good track record on safety.

Requires improvement

Wards for people with learning disabilities or autism

Between July 2019 and November 2019 there were nine serious incidents reported by the provider. None of the incidents resulted in unexpected deaths. The most common theme, comprising four incidents, was patients ingesting batteries.

Improvements had been made to safety following these incidents. The hospital managers had introduced a battery management protocol, individual battery risk assessments and management plans for individual patients. There were daily battery registers maintained for each ward and these were audited by hospital security staff.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated the most serious incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Overall there was a high level of reporting of incidents at the hospital and this included all levels of restraints and any patient interactions that involved abuse or harm.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation, if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff and patients told us they received debrief and support after serious incidents and the psychology department offered debrief support.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

The most serious incidents were always discussed at the daily morning meeting and allocated for investigation. Staff received feedback from the investigation of incidents, both internal and external to the service. There was good practice in place to share alerts around patient safety incidents from around the Huntercombe Group and from national safety alerts.

Staff were debriefed and received support after a serious incident. They met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. This was demonstrated in the local protocol to limit self-harm through swallowing batteries as an addition to the group wide policy focusing on local lessons and the specific risks of their patients. Psychological support was available to staff and repeat sessions were provided if required to ensure all staff received support

Whilst incidents had been investigated staff had not closed them down on the system and some still needed a senior member of staff's signature to indicate they had been closed.

We sampled 40 of these open incidents (some randomly and others following themes; for example, falls and staff misconduct). We found two incidents where staff behaviours towards patients had been highlighted as a concern. One had been captured in a local thematic review but there was no investigation or record of a discussion with the member of staff involved. The other had not been investigated or captured within the thematic review and related to professional boundaries in a relationship between a staff and patient.

The provider agreed to investigate both and review all open incidents to ensure no other incidents requiring action had been missed. By the end of our inspection, they had provided us with a plan to complete this review. They had changed the local system of allocation to prevent any further increase in the backlog of incidents remaining open and overdue. We were assured that the information in the open incident reports had been used to inform local audits on restraint and used to review positive behaviour support plans for individual patients as appropriate.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit.

They worked with patients and with families and carers to develop individual care and support plans, and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

Staff completed a comprehensive mental health assessment of each patient, either on admission or soon after. We looked at 24 patients' care records that showed that staff assessed the mental health needs of all patients in a timely way and identified all patients' needs.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward and had an up-to-date hospital passport. Each patient had a comprehensive physical health action plan, which detailed all of their physical health concerns and related history. These included information of weight related issues, dietary needs, sleep problems, pain control, mobility problems, breathing problems, blood pressure and circulation problems, physical disability, and sensory and communication problems and needs.

Staff developed a comprehensive care plan for each patient, involving their carers, where appropriate, ensuring that they met their mental and physical health needs. These included areas such as mental state and mood, medicine administration, physical health monitoring, risk and safety, challenging behaviour, activities, and interventions. Staff and patients regularly reviewed and updated care plans and positive behaviour support plans. Care plans were personalised, holistic and recovery-oriented. The care plans included communication passports and contingency plans. Staff gave patients copies of easy read care plans. The occupational therapists created easy-read documents after each patients' multidisciplinary meeting.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.

We reviewed 27 prescription charts and spoke to doctors who were responsible for prescribing medication. Doctors followed National Institute for Health and Care Excellence (NICE) guidelines such as challenging behaviour and learning disabilities (NICE guideline 11), mental health problems in people with learning disabilities (NICE guideline 54) and medicines adherence (clinical guidance 76) when prescribing medicines. We saw that patients had their medication reviewed weekly that included information on possible drug interactions, minimum effective doses, contra-indications, side effects and health checks required. Staff also monitored and reviewed the effectiveness of the medicines prescribed. Care plans referred to National Institute for Health and Care Excellence guidelines. The provider had signed up to 'STOMP'- Stopping the Over Medication of People with learning disabilities, autism or both. This was a national initiative and the hospital were committed in its support of this project.

Patients on antipsychotic medication were monitored for weight, blood pressure, fasting blood glucose and lipids. We found that two patients on more than one antipsychotic medicine, (on Birch and Ash) had clear reasons for that recorded and were supported by a second opinion appointed doctor (SOAD).

Staff identified patients' physical health needs and recorded them in their care plans. There was a full-time practice nurse on site that attended to all physical health needs of patients. The GP ran a clinic every week at the hospital. Staff could make referrals to the GP at any time for any physical health problems. Also, patients had good access to physical healthcare specialists for specific, identified needs. This included close links with dentists, chiropodist, diabetic team and neurologists for patients with epilepsy. Patients told us that the staff addressed any physical health concerns they had. Patients could also access the ward doctor with concerns or questions that the nursing team could not address.

Staff met patients' dietary needs, assessed those needing specialist care for nutrition and hydration needs and referred them to a dietician if required. Staff monitored fluid and food intake for patients with medical conditions that would put them at risk of being malnourished. We

were told that the speech and language therapist was not dysphasia trained. However, the speech and language therapist would provide awareness training as part of the induction and will do an initial assessment to see if external referral is required. The hospital could access a speech and language therapist externally who would carry out any dysphagia assessments when required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients told us that they discussed their physical health regularly with staff where staff would encourage them to stay active, eat healthy and try to avoid or reduce unhealthy activities such as smoking. Patients also had use of the gym within the service.

Staff used recognised rating scales to assess and record the severity of patients' conditions, care and treatment outcomes. Staff used a range of outcome measures such as health of the nation outcome scales (HoNOS), spectrum star (an outcome measurement tool for people with autism) and model of human occupation screening tool (MoHOST) to ensure that patient progress and recovery were monitored. Staff monitored progress regularly in care records and recorded data on progress towards agreed goals in each patient's notes.

Staff used technology to support patients.

Staff took part in clinical audits. such as, care plans, risk assessments, security checks, infection control, clinic room, restrictive practice, physical health audits and discussed the content and quality of records with their peers. Managers used results from audits to make improvements.

Skilled staff to deliver care

The service had access to the full range of specialists required to meet the needs of patients on the wards. Although managers provided an induction programme for new staff including bank and agency they did not always ensure they had staff with the range of skills needed to provide high quality care.

The service had access to a full range of specialists to meet the needs of the patients on the wards. This included learning disabilities, mental health, registered general nurses, psychologists, doctors, social workers, support workers, recovery support workers, speech and language and occupational therapists.

Nursing staff told us they received only basic autism awareness as part of induction and had not received any further or ongoing specialist autism training that would equip them to meet the complex needs of their patients. Staff told us they would like more specialist training in autism to ensure they could keep up with new developments and feel confident in the care they delivered.

Nursing staff were not trained to meet patients' specific communication needs such as picture exchange communication system (PECS) and Makaton. This limited the effectiveness of strategies to engage with and maintain the skills of some patients. For example, the hospital staff were aware of a patients' communication needs and had picture exchange communication system cards in relation to food choices and not in other communication needs. The patient had a risk of constipation identified within their assessment. However, this was not reflected in the patient's care plan. It was unclear how nursing staff were identifying and addressing his care appropriately to meet his needs. This meant that staff had not put in place effective plans to minimise, manage and avoid constipation.

This was of great concern as staff told us they were not aware and were not implementing recommendations set out in the Learning from Deaths Mortality Review (LeDeR) about the factors that can contribute to premature mortality in people presenting with learning disabilities.

Not all the qualified nurses at the unit were registered as learning disability nurses. There was no specific training available to support nurses from other specialisms to develop the core skills and understanding of a learning disabilities nurse.

Both the medical director and head of nursing did have training in the assessment and diagnosis of autism spectrum disorders.

The medical director had attended a Royal College of Psychiatrist continuous professional development update training in autism spectrum disorder. No evidence of any other specialist training in the management of learning disabilities and autism was shared with us.

All new staff, including bank and agency, went through an induction program covering areas such as ligature risks, the ward environment policies, guidelines and expectations.

Managers gave each new member of staff, working on the ward for the first time, full induction to the service before

they started work. The hospital gave bank and agency staff formal inductions if they were new. Agency staff on contracts received a full corporate induction. On inspection we saw two agency staff working as supernumerary whilst on their induction. Staff confirmed that they received an appropriate induction.

The provider had set a target that 85% of its staff should receive regular supervision. As of September 2019, the provider reported the following average supervision rates: Elm 87%, Chestnut 89%, Maple 87%, Willow 100%, Ash 86% and Birch 63%.

In the last inspection in September 2017 we highlighted that staff supervision was not consistently carried out in a structured way that captured areas of discussions and it varied in detail and quality. On this inspection there had not been improvements. Concerns raised in the previous inspection had not been addressed. The manager reported that the latest supervision rates for January 2020 were between 80% and 100%, for permanent, bank and agency staff. The managers told us they ensured all staff were provided with supervision and appraisal of their work performance. On this inspection, staff reported they received regular supervision. Agency and bank staff confirmed they received regular supervision. Some staff reported to us that they had different supervisors for each session and that they did not know the supervision policy. Some said they found their supervision and appraisals as useful tools in reflecting and developing their practice. We reviewed 15 staff files, we struggled to find evidence that all staff received supervision regularly and consistently. The form used was not clearly structured although it captured discussion there was no consistency and actions from previous supervision not carried forward. Competence and level of skills for the supervisors differed. Some were detailed and some did not discuss the key areas of practice that would be seen as supporting staff to effectively do their job and no discussion on training and development captured. Some records we reviewed indicated that staff had only started to get supervision consistently within the last two to three months, while other records lacked evidence that supervision had taken place for over three to six months. The hospital manager had no oversight on this. He told us there was a supervision structure in place, however, there was no clear monitoring in place to ensure the quality of supervision was of good standard. We found a number of unfiled supervision records some dating back to January 2018.

Managers told us they supported staff through regular, constructive appraisals of their work. Appraisal rates as of September 2019 were, Elm –100%, Chestnut 83%, Maple 95%, Willow 95%, Ash 96% and Birch 100%. We also saw that most of the appraisals were completed within the two months prior to inspection.

Managers made sure staff attended regular team meetings or gave information to those that could not attend. We reviewed a sample of team meeting records from November 2019 to January 2020 and attended one team meeting. The agenda and structure of the meetings were detailed and included information staff needed to know and gave them an opportunity to provide feedback. Agenda covered, corporate and local communications, health and safety, policy and protocols, HR and training, risk register, best practice, serious incidents and lessons learnt. It included any actions from previous meetings and actions to be carried forward.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Support workers gave us examples of being supported to complete their nurse training.

Managers recognised poor performance, could identify the reasons, dealt with these in a timely manner and received support from the human resources team for any disciplinary issues. There had been five staff suspended from October 2018 to September 2019.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These meetings involved all different professionals within the team and sometimes included other professionals from external organisations and family members where patients had consented. The advocate also attended the meetings when required by a patient. We observed a multidisciplinary team meeting and reviewed some of the multidisciplinary team meeting notes

and saw in depth discussions that addressed the identified needs of the patients such as risk, safeguarding issues, physical health issues, medication review, discharge planning and changes to care plans. Staff took into account patient wishes and considered a holistic approach to patient care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We attended one daily morning meeting held on the wards to discuss any incidents, leave, requests from patients, safeguarding issues, physical health, mental state, review of observations and any appointments. This ensured that all urgent issues were addressed and level of observations were reviewed on daily basis as a multidisciplinary team.

Ward teams had effective working relationships with other teams in the hospital. They had regular discussions with the therapies team, catering department and the administration team.

The provider had effective working relationships with external teams and organisations. External professionals from other services that were involved in patient care were invited to ward rounds, care programme approach meetings and involved in community treatment orders. This included care coordinators, social workers, community team managers and commissioners. They had effective working relationships with staff from services that would provide aftercare, following the patient's discharge and engaged with them early in the patient's admission to plan discharge.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Code of Practice and could describe the Code of Practice guiding principles. Training records indicated that 97% of staff had received training in Mental Health Act . Staff showed a good understanding of the Mental Health Act and the Code of Practice.

At the time of inspection all patients in the hospital were detained under the Mental Health Act. We reviewed 24 records of detained patients which were up to date, stored appropriately and compliant with the Mental Health Act and the Code of Practice.

Consent to treatment and capacity forms were appropriately completed and attached to the medication charts of detained patients.

The wards kept clear records of section 17 leave granted to patients and patients could take their leave when this was agreed with the Responsible Clinician and with the Ministry of Justice (when appropriate). Staff made patients and their carers aware of the conditions of leave and any risks and advised them on what to do in the event of emergency.

Staff had access to support and advice from their Mental Health Act administrators on implementing the Mental Health Act and its Code of Practice.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time. They used easy read information forms. Patients we spoke with confirmed that their rights under the Mental Health Act that had been explained to them.

The wards displayed information on the rights of detained patients where it was easily accessible. The Independent Mental Health Advocacy (IMHA) services were readily available to support patients, we saw information on posters. Staff were aware of how to access and support patients to engage with the independent mental health advocate when needed. Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. This ensured that staff offered patients the opportunity to understand their legal position and rights in respect of the Mental Health Act.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Requires improvement

Wards for people with learning disabilities or autism

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and the Mental Health Act administrator made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Training records showed that 86% of staff had received training in the Mental Capacity Act. Staff spoken with demonstrated a good understanding of Mental Capacity Act and they could explain the five principles.

None of the patients were subject to Deprivation of Liberty Safeguards and there were no deprivation of liberty safeguards applications made in the last six months. There was a clear policy on Mental Capacity Act and Deprivation of Liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We reviewed 24 records with detailed information on how capacity to consent or refuse treatment had been sought. When appropriate, staff had involved families, commissioners and an independent mental capacity advocate when discussing care and treatment decisions.

Staff conducted capacity assessments for each patient at the time of admission. This assessment focused on the patient's understanding around being admitted to the ward and their capacity to consent to treatment. The capacity of individual patients was discussed on a decision specific basis at multi-disciplinary meetings and ward round meetings. Patients were supported to make their own decisions.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients. For example, on Birch ward, when a patient lacked the capacity, staff recorded in patients' records to show that they had gone through the process of properly assessing capacity following the four-stage assessment. The multi-disciplinary team made decisions in the patient's best interest, recognising the importance of their wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service completed audits and monitored how well it followed the Mental Capacity Act and staff acted when they needed to make changes to improve.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Positive and caring relationships were developed between patients and staff. We observed that staff were kind, warm and friendly with people, knew their patients well and were genuinely concerned for their wellbeing.

Staff treated patients with compassion, kindness and always maintained dignity. We spoke with 13 patients and they were all positive about staff and highlighted that how supportive and caring the staff were. Patients said that staff treated them with respect and were very responsive to their needs.

Requires improvement

Wards for people with learning disabilities or autism

We observed a range of interactions between staff and patients. This included one-to-one support, support with personal hygiene, and engagement in activities and therapy sessions. Staff were discreet, respectful, kind, caring and staff were polite in the way they talked to patients.

Staff gave patients help, emotional support and advice when they needed it. Staff responded to patients in a reassuring way and were available when needed.

Staff were sensitive to patients' feelings, needs and preferences. Staff knew how to communicate effectively with patients and took their time to listen and explain things to them. There was a feeling of positive relationship and interactions.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of consequences. All staff we spoke with were clear that there was an open and transparent culture within the service and anyone who showed any disrespectful or abusive behaviour was dealt with quickly and efficiently by managers. We were aware of at least two cases within the 12 months prior to inspection where staff had been dismissed due to disrespectful comments and inappropriate behaviour towards patients. Managers told us they have no tolerance to poor attitudes within the staff group and were quick to act when they aware of an issue. Staff were passionate about not tolerating abuse at any level.

Staff followed policy to keep patient information confidential. They ensured that confidential conversations took place in appropriate settings.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the hospital as part of their admission. The hospital provided a welcome pack to all patients on admission. The welcome pack was in an easy read picture format. Patients confirmed that staff had shown them around the ward on admission and introduced them to staff and others. The hospital also had a welcome pack for the carers. This explained how the service worked and helped them to understand what to expect.

We were told that not all patients and relatives had the opportunity to visit before an admission because some admissions were from far away and some were urgent. However, staff informed us it was possible to visit if planned and agreed before admission. Most patients told us they had visited the hospital prior to being admitted.

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us that they were involved in updating their care plans and risk assessments on a regular basis. Each patient received their personal activity timetable.

Staff made sure patients understood their care and treatment. We saw care plans and activity plans in easy read format or in pictorial form. They were easy to understand and for those more able patients, they had copies within their rooms. Some patients did not have capacity to fully understand their care and treatment plans. However, staff worked with them to undertake activities they enjoyed.

Staff involved patients in decisions about the service and could give feedback on the service and their treatment, when appropriate. The hospital ran a group called 'Noise voice choice meeting' that was chaired by patients where they discussed issues about how the service was run. Staff produced easy read documents about the meetings at the hospital. With support, patients had the opportunity to communicate what they did and didn't want or like.

Staff encouraged patients to maintain and develop independence in areas where they were assessed to be independent. For example, staff involved patients in activities of daily living skills such as cooking, cleaning, laundry, shopping, managing finances and medication and community access. We saw patients working on the hospital's café, which they were proud of and proved to be popular.

Requires improvement

Wards for people with learning disabilities or autism

Staff promoted patients to take control and have choice over their lifestyles.

Staff made sure patients could access advocacy services. The advocates attended patient review meetings when required. There was an advocate based on site Monday to Thursday. Patients told us that they could access advocacy services when needed.

Staff supported patients to make advanced decisions on their care.

Patients were involved in the recruitment of staff and recruitment open days.

Involvement of families and carers

Staff supported, informed and involved families or carers appropriately. Family members and carers were invited to ward round meetings and care programme approach meetings. Most carers reported that they were actively involved in the planning of care and treatment for patients. One carer reported that previously the hospital had not kept them updated but this had improved and were kept updated, involved in the multi-disciplinary team meetings which were helpful to the family and they could have their input at arranging the right transition.

Patients we spoke with said their family members were involved in their care if they wanted. Patient records showed that staff contacted families and carers to provide updates and included details of family visits and input. Staff considered family members' views about care and treatment plans.

Staff helped families to give feedback on the service and followed the principles of Ask, Listen, Do in relation to feedback, concerns and complaints.

Staff gave carers information on how to access a carer's assessment.

There was a new carers booklet that also included information on how to contact the hospital manager directly if they had concerns. This was an improvement since the last inspection.

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

(for example, to feedback?)

Good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

On the first day of our inspection on 28 January 2020, there were 33 patients in the hospital.

The provider accepted referrals from all of England and Wales. An initial assessment was undertaken to decide whether the needs could be appropriately met and the funding for the placement would be agreed with the commissioners. The manager told us they had established close links with the local Care Commissioning Groups and this had increased the number of local patients being admitted to the unit. There were 24 patients out of 33 that were from West Midlands area and the border with Wales.

The provider informed us admissions were planned. During our inspection we observed the admission of a new patient on Elm ward. Managers informed us that staff from the hospital had been to assess the patient prior to the admission and identified the patient's immediate needs. During the hospital's morning meeting, staff had discussed the admission, but later staff failed to effectively manage admission of the new patient. Needs identified prior to admission were not addressed at point of admission, there appeared to be no oversight of managing appropriate staff for the new admission to effectively meet the patients immediate identified needs.

Average bed occupancy for the six month period from April 2019 - September 2019 was, Birch 99%, Ash 91%, Chestnut 92%, Maple 76%, Willow 80% and Elm 44%.

The average length of stay over the 12 month period from September 2018 – October 2019 was Birch 43 months, Ash

63 months, Chestnut 24 months, Maple 21 months, Willow 34 months and Elm 17 months. The length of stay was longer in some wards due to patients that were on a Ministry of Justice restriction order.

When patients went on leave there was always a bed available when they returned. Each patient had their own room or bespoke area which would not be moved or changed.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. Staff took into consideration each patient's individual risk and their social interactions with other patients, before moving them to other parts of the hospital.

Managers and staff worked to make sure they did not discharge patients before they were ready Staff did not move or discharge patients at night or very early in the morning. When patients were moved or discharged, this happened at an appropriate time of day. The multidisciplinary team planned and co-ordinated the discharges with other necessary external agencies in a collaborative way well in advance.

It was rare for any patients to require a psychiatric intensive care bed. If this did occur, the service would continue to care for the patient while a more appropriate bed was being sourced.

Discharge and transfers of care

Managers monitored the number of delayed discharges. The hospital had one delayed discharge in the six month period from April 2019 – September 2019. The delay was due to problems in identifying a suitable placement recommended in care treatment reviews and discharge plans. Escalation meetings were held weekly to discuss progress.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients visited new placement on trial leave to see how they coped as part of their transition. During our inspection, one patient from Elm was in the process of his transition to a stepdown community service and getting familiar with the staff.

There were clear discharge plans for two patients on enhanced observations within long term segregation The provider had worked with patient's care coordinators and clinical commissioning groups to identify suitable residential placements, including exploring options within the provider's own pathway. The multi-disciplinary team put in measures to support the patients through this period and had created tailored discharge plans for each patient. The provider had developed their own community based service in Stoke to support the early discharge of patients whilst maintaining some continuity of care as the multidisciplinary team helped support the resettlement of patients.

The hospital supported some patients to move to community placements and have their own tenancy within the providers pathway.

Staff supported patients when they were referred or transferred between services. Staff stayed with patients when admitted into acute hospital for physical health problems.

The service followed national standards for transfer. The care programme approach meeting was held to discuss the discharge plan that included the crisis plan. Each patient had a care and treatment review carried out in line with NHS England transforming care programme.

The facilities promote recovery, comfort, dignity and confidentiality

Although the environment was not autism friendly, the design and layout, of the ward supported patients' privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw posters, photographs, personal bedding and other personal items in patient bedrooms. Personalisation across the rooms was variable - this was dependant on individual need and risk. Staff knew patients well and judged their level of risk and what they wanted in their room. Staff were responsive to their individual preferences. For example, one patient liked to have their mattress on the floor.

Patients had a secure place to store personal possessions. There were lockable facilities in bedrooms which patients had a key for. Some patients had a key to their own bedrooms, this was individually risk assessed.

Requires improvement

Wards for people with learning disabilities or autism

Staff used a full range of rooms and equipment such as clinic rooms, activity and therapy rooms and a family room, to support treatment and care.

The hospital had not carried out an autism friendly assessment (autism friendly environment checklist) to ensure that reasonable adjustments were made to meet the national guidelines for autism friendly environment National Institute of Health and Care Excellence clinical guideline [CG142]. The managers had also not considered the conflicting sensory needs of patients living in the same ward. Ward environments were not tailored to the sensory needs of individual patients.

There was one sensory room located in Maple were other patients in the hospital did not have easy access to. The sensory room had lights, a computer and projector. However, staff told us there had not been an assessment of the sensory needs of the patients on the ward for the effective use of the room and the equipment required. Managers told us the provider was investing financially into the service, which would include environmental works such as a sensory garden.

The service had quiet areas and a room where patients could meet with visitors in private. There was a designated family room where patients could meet visitors privately. There was another family room in the lodge where families with children could meet patients privately.

Patients could make phone calls in private. Patients were permitted unrestricted access to their own mobile telephones once this was individually risk assessed.

The service had an outside space that patients could access easily. Patients could access the large open space surrounding the buildings.

Patients could make their own hot drinks and snacks and were not always dependent on staff individually risk assessed.

The service offered a variety of good quality food. The chef was responsive to individual needs and dietary requirements.

The hospital offered a wide range of daily activities to patients including weekends and evenings. We had identified this as an area requiring improvement at our 2017 inspection. On this inspection we found improvements had been made. The majority of patients said that what they liked most about the service was that there had been improvements to the activities and group work particularly around weekends and evenings. One carer told us staff had taken their relative rock climbing. Staff caring for patients on constant observations informed us they still adhered to individual patient activities. Each patient had an individual rehabilitation structured daily programme of activities which were related to their individual needs. The occupational therapist assessed patients and encouraged them to actively engage in routine meaningful and purposeful activities that promoted their skills such as cooking, education, voluntary work, music therapy, animal care, understanding finances, making their on hot drinks, community access and laundry. The hospital had recovery support workers that supported patients with activities and engagement.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities in the community and supported them to access them. Patients had regular access to the local shops and leisure facilities. The service had four vehicles they used for patient transportation. However, some patients reported that their leave was delayed due to there being not enough drivers.

Staff helped patients to stay in contact with families and carers. Some patients had mobile phones, so their families could speak to them whenever they wanted. Families could visit whenever they wanted, and patients took leave to their family homes whenever appropriate. One carer was really pleased that the hospital had facilitated a visit that was 120 miles return journey.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. The speech and language therapist supported patients to register in the recent General Election.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with advocacy and cultural and spiritual support.

Requires improvement

Wards for people with learning disabilities or autism

The service could support and make adjustments for disabled persons. There was a ramp that could be used to access the buildings for those with wheelchairs. There was a disabled toilet facility in the reception area.

The hospital had information leaflets in English. Staff told us that leaflets in other languages could be made available when needed.

Staff gave patients relevant information that was useful to them such as the service provided, treatment guidelines, medical conditions, medicines, safeguarding, advocacy, patient's rights and how to make complaints. Most of the information was available in easy read leaflets, signs, symbols, photographs and photographs.

Interpreting services were available when required. Staff knew how to access these services.

We saw staff considered patients' protected characteristics in line with The Equality Act 2010, such as age; disability; race; religion or belief and sex.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Everyone agreed the food was nutritious and tasty. The chef could adapt recipes and accommodate anyone's specific needs

The provider had a multi-faith room in the Lodge. Staff told us they supported patients to attend faith centres in the local community to meet their spiritual needs. The hospital had contact details for representatives from different local faiths that visited the hospital.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service received 14 complaints from September 2018 to September 2019, none were upheld, and none were referred to the Ombudsman. Patients had complained about their care and treatment or staff attitudes. Four complaints related to staff attitude to one another. The manager reintroduced staff forums to encourage open discussions amongst staff. The service received 13 compliments within the same period. The service used compliments to learn, celebrate success and improve the quality of care.

Patients relatives and carers knew how to raise concerns and complaints and felt able to do so. The hospital had information on how to make a complaint displayed in patient areas and patients were given this information. Patients could raise concerns with staff anytime. Staff understood the policy on complaints and protected patients who raised concerns or complaints from discrimination and harassment. Staff told us they tried to resolve patients' and families' concerns informally at the earliest opportunity.

Managers investigated complaints and identified themes. Staff told us that any learning from complaints was shared with the staff team through staff meetings, handovers and emails and the managers made changes where it was required.

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

Requires improvement

Leadership

Leaders had the skills and knowledge to perform their roles and were visible in the service and approachable for patients and staff.

There had been changes to leadership since last inspection. The hospital director had been in post since May 2019 and had been working on a recruitment and retention strategy. Each pathway had a service lead. There was stable leadership at ward level, with service managers and senior nurses. There was a new head of nursing from October 2019. The hospital had also recently introduced a quality lead role to assist in improving the standards of care at the service as well as improving some of its governance structure. Although the team were in its infancy stage of embedding their presence, the management team was working together to improve care.

The leaders were visible in the service and approachable for patients and staff. Patients and staff spoke highly of the medical director and reported that they were well supported by medical leadership in the hospital. Most staff spoke highly of the support they received from the management team. However, some staff said that while managers were approachable, they did not always act on all matters raised.

Requires improvement

Wards for people with learning disabilities or autism

Although leadership development opportunities were available, including opportunities for staff below service manager level, there were no clear minimum competencies required identified for progression into leadership roles within the hospital.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

The service had a vision that most staff knew and understood. The organisation's values were well embedded and staff could explain how they influenced their everyday work. The vision and values were displayed in the wards for staff, patients and visitors.

The wards held regular ward meetings which also discussed the values, the strategy and plans of the organisation on how to achieve high quality care.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. They reported that they were not involved in all discussions but at times they were asked for ideas about how the service was run.

The hospital had recently opened a stepdown unit as a way of managing the local discharge pathway and had consulted their stakeholders on their vision for this.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.

Most staff felt respected, supported and valued by their managers. Staff reported feeling positive and proud about working for the organisation. Staff we spoke to told us that the morale within the hospital had improved over last two months and they spoke positively about the culture. The provider had just introduced the "Joy in work" and "Just Culture" program to engage with staff and improve motivation and contentment at work. In a recent local staff survey in November 2019, 64% of staff said they felt listened to.

Staff we spoke to said they felt happy at work. Agency staff told us the managers appreciated them and that they felt part of the organisation.

Staff told us that the culture on the wards was friendly and open with team members happy and willing to support each other. Staff stated that the team worked well together with managers and leaders providing effective support through busy periods.

Staff felt confident in raising issues without fear of retribution and that any concerns were addressed and taken seriously.

Staff knew how to use the whistle-blowing process and about the role of the freedom to speak up guardian. Staff told us that there was a number that they could call and remain anonymous. They told us they felt confident to do so when required and managers encouraged them to do so.

Managers dealt with poor staff performance when needed. There was support from the human resources team if required. Managers told us they had used the disciplinary procedure to improve the performance of staff following issues of poor performance.

The teams worked well together and there were established core teams in each ward that had a leader and effective working relationships, including the agency staff. Staff were keen to support each other to deliver good quality patient care. Staff described their teams as cohesive and dedicated to supporting each other to provide high quality patient care. The hospital manager had recently reintroduced a staff forum. We saw that all teams had good working relationships and were well coordinated.

Managers provided staff with appraisals that included conversations about career development and how that could be supported. Staff were able to tell us some of examples of training courses they had been involved in as part of career development, for example, some support workers were supported to attend nurse training.

There was an active strategy to consistently promote equality and diversity around protected characteristics in day to day work. There was a nationwide Huntercombe staff group which staff could access. Staff told us that they attended training in equality and diversity. However, there was no lead for equality and diversity at this hospital. The hospital did not run local forums on equality and diversity.

The service reported a staff sickness and absence rate of 5.4% from October 2018 to September 2019.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The hospital also signposted staff to 'MyfamilyCare' – this was a web-based solution where staff could access all kinds of information about different life events. Managers discussed with staff about their well-being and signposted them for support if needed.

Managers had recently held listening groups for staff, in November 2019, to allow them to raise any issues and had completed an action plan from their feedback to improve the service.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level.

We were not assured that there was oversight on the operational governance processes to manage quality effectively. Although the service had a good dashboard that collected essential information from all wards, the management team did not always have the detailed oversight of some processes, such as completion of staff supervision records.

Although staff received basic awareness of learning disabilities and autism, there was no in-depth specialist training offered for autism or the specialist communication skills to address needs of patients.

The provider had not ensured that the environment was comfortable and conducive for patients with sensory needs and that reasonable adjustments were made to meet the National Institute of Health and Care Excellence clinical guidelines for an autism friendly environment.

There was a backlog of incident investigations awaiting completion. To address this, the hospital conducted daily meetings attended by all service managers, senior managers and senior staff to review all incidents that had happened in the last 24 hours. The managers would immediately distribute the headlines of lessons learnt, implement risk management plans and conduct debriefs with teams. The allocation of incidents to be investigated was made at this meeting. The protocol was to be changed to overcome the problem of the build-up of a back log of incidents not being closed.

There was a clear framework of what was discussed at ward team meetings to ensure essential information such as learning from incidents and complaints were shared and discussed.

The hospital manager had developed some ways to help communicate key information to staff through forums such as monthly staff newsletters and ensured that the monthly lessons learnt bulletin was displayed across the hospital.

Although the hospital had difficulty recruiting substantive staff, they ensured that the shifts were covered with sufficient numbers of qualified nurses and nursing assistants to ensure patients received the right care for them at the right time. All agency staff also received appropriate induction and supervision. The provider had taken action since our inspection in September 2017 to ensure there were strategies in recruitment and retention of the workforce that included flexible working and increase in support workers rates.

Staff undertook and participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. The hospital had recently employed a quality lead to provide assurance that the quality and standards of care were effectively monitored.

Staff understood the arrangements for working with other teams, both within the organisation and external to meet the needs of the patients. There were good working relationships with the providers step-down unit, commissioners, local police, local authority, local community, voluntary sector and GP.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Managers maintained and had access to the risk register. We reviewed the risk register for the provider and saw that it was up to date and reflected the risks within the service. Staff were able to escalate issues to the manager who would include them on the risk register.

Requires improvement

Wards for people with learning disabilities or autism

The service had plans for emergencies that explained measures the service would take to ensure safety of patients in the event of an emergency or adverse weather conditions.

Information Management

Ward teams did not always have access to the information they needed to provide safe and effective care.

Senior staff reported that methods used to give information to management were not always easy to use as information was saved in various places. The service used systems to collect data from wards that were at times over-burdensome for frontline staff.

The information technology infrastructure, including the telephone system and closed-circuit television, worked well and helped to improve the quality of care. All permanent staff had access to the equipment and information technology needed to do their work. However, not all agency staff had access to information technology

Information governance systems ensured the confidentiality of patient records. Staff made notifications to external bodies as needed. The Care Quality Commission received relevant notifications as required. The local authority received safeguarding alerts notifications.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Although information recorded was timely and accurate it was not always in an accessible format.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

The service had monthly staff meetings within each wards. These meetings were well-organised and with standard agendas. Records of issues raised and planned actions were kept. Learning from incidents, safeguarding alerts and complaints was routinely discussed at staff meetings. Staff told us that meetings were well-run and informative.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The service received feedback from patients and carers, in ways such as suggestion box, surveys, meetings, open discussion, and the advocate.

Staff and patients had access to up-to-date information about the work of the provider and the services they used. The noticeboards were full of information about the service, patients had weekly community meetings. The carers and families told us the communication with the hospital had improved on keeping them well informed about the service. The hospital manager and senior leadership team had met with a selection of families and carers in December 2019 to seek their views, update them about the service.

The provider had ways to keep their staff and patients well informed and up to date about the service. They used intranet, emails, newsletters, noticeboards and face to face meetings. Agency staff we spoke to told us they felt part of the team and the managers fully supported and engaged with them.

Patients and carers were fully involved in decision-making about changes to the service. Patients used the noise voice choice meetings.

Patients and staff could meet with members of the provider's senior leadership team to give feedback. Managers took the feedback from patients seriously.

Directorate leaders engaged with external stakeholders such as commissioners and local authority. NHS Wales had visited in October 2019 to conduct their quality audit.

Learning, continuous improvement and innovation

The service had least restrictive practice well embedded and had implemented the use of pro-active strategies. They minimised the use of coercive practices and prevented the misuse and abuse of restrictive practices.

Staff did not participate in research.

Staff did not participate in national audits and accreditation schemes relevant to the service and learned from them.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that staff are supported with regular supervision and managers have reliable systems to monitor this. **Regulation 17(2)(d)**
- The provider must ensure that staff working with patients with autism have specialist training and skills to address the complex needs of patients with autism and particularly the communication needs of patients using PECS and Makaton. **Regulation 18(2)(a)(b)**
- The provider must ensure that system used to access information is appropriately organised and fully integrated together. **Regulation 17(2)(a)(c)**

Action the provider SHOULD take to improve

- The provider should ensure that they address and monitor level of cleanliness on Chestnut. **Regulation 15 (1)(a)**
- The provider should ensure that blind spots on ward stairs have adequate mitigation. Convex mirrors within the stairs should service the purpose of mitigating blind spots. **Regulation 12 (2)(b)**
- The provider should ensure that they continue to monitor and signoff all incidents in a timely way. **Regulation 17 (2)(a)(b)(f)**
- The provider should ensure that they carry out an autism friendly assessment of the environment to ensure that the environment is therapeutic for patients with autism and sensory needs and to ensure the environment is comfortable for all patients. **Regulation 17 (c)**
- The provider should ensure that staff always follow systems and processes to safely store and manage medicines. **Regulation 12 (2)(g)**

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not ensure that system used to access information was appropriately organised and fully integrated together.** **The provider did not ensure that staff were supported with regular supervision and managers did not have reliable systems to monitor this.** This was a breach of regulation **17(2)(a)(c)(d)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure that staff working with patients presenting with complex autism needs have specialist training and skills to address the complex needs of patients with autism and particularly the communication needs of patients using PECS and Makaton.** This was a breach of Regulation 18(2)(a)(b)