The Whitepost Health Care Group

Shrewsbury Court Independent Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Shrewsbury Court is an independent hospital that previously provided long stay/rehabilitation mental health inpatient care for working-age adults. Over the last 12 to 18 months the provider has been undertaking a move towards delivering a different model of care, from purely long stay/rehabilitation, to providing a long stay/rehabilitation and an inpatient service for those with learning disabilities and autism.

The previous rating of 'good', given for the long stay/rehabilitation core service, on 10 November 2020, remains the same for long stay/rehabilitation wards only. We will return to inspect this core service at some point in the near future.

There are now only two wards that provide long stay/rehabilitation care with care for people with a learning disabilities and autism provided on three of the wards.

At this inspection we only inspected the core service 'wards for people with learning disabilities and autism' and have therefore, only provided a rating for this service.

We expect those that provide services to people with a learning disability and autistic to be able to demonstrate how their service meets the needs of patients in line with current guidance and best practice. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people. This guidance requires that people with a learning disability are guaranteed the choices, dignity, independence and good access to local communities that most people take for granted.

On 24 August 2021 following our inspection, we served the provider with an urgent notice of decision to impose conditions on their registration under Section 31 of the Health and Social Care Act 2008. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. We took this urgent action as we believed that people would or may be exposed to the risk of harm if we did not do so.

The conditions placed require the provider not to admit or readmit any patients to Lavender, Aspen, Mulberry wards and Aspen Annex without prior agreement from CQC. In addition, the conditions require the provider to confirm in writing the actions they will take immediately and in the longer term to ensure medicines are managed safely, that there are robust systems of governance in place to ensure clear oversight of the care being delivered, ongoing monitoring and that improvements will be made in a timely manner.

As a result of our serious concerns about this service CQC's Chief Inspector of Hospitals has placed this service in special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration. The service will be kept under review and, if needed, could be escalated to urgent enforcement action, including that described, at any time.

We rated 'wards for people with learning disabilities and autism as inadequate because:

Summary of findings

- The service was not providing safe care. The inspection team had to ask the provider to remove obvious and significant ligature anchor points on the first day of the inspection. The provider removed these when asked but had not identified these as a high risk. The ligature assessment that had been undertaken did not clearly explain to staff how to manage the identified ligature risks. The actions described to reduce the risk were the same regardless of the risk that had been identified.

- The required actions identified in the fire risk assessment documentation, regarding gaps between fire doors and frames, had not been fully completed. In May 2021 an external consultant in fire safety identified that that fire compartmentation was not fully effective across the premises and there were "excessive gaps between fire doors and door frames". We also noted gaps between fire doors during our tour of the property. The remedial action needed to make fire doors efficient was not included in the risk register or addressed in the provider's action plan documents. The providers could not be assured the doors were able to perform their primary function of protecting patients and staff in the event of a fire and of their safe evacuation from the building. There was also a lack of oversight of the fire risk action plan from senior leaders.

- The wards and outdoor areas were not clean which placed patients and staff at risk of harm and at risk from the spread of infection. We saw dirty marks on doors and door frames and some were damaged; bedframes were also dirty. There was graffiti on walls in some patients bedrooms that had not been cleaned off or painted over when previous patients had been discharged, there was litter in the courtyards which patients accessed and in Aspen ward there was a strong smell of urine which were extremely unpleasant. The Infection Prevention Control (IPC) audits for the purpose of preventing the spread of infections were not consistent with what we found on inspection.

- The wards environment were not safe or maintained to an appropriate standard. There were fixtures and fittings in need of repairs. For example, some of the sofas were in need of repair or replacement. On Aspen ward tape had been used to try and seal the edges of a door to an en-suite facility to try and stop the strong smell of urine, due to a broken toilet, seeping out. We found damaged windows and a range of damaged equipment. On Lavender ward cleaning chemicals and paint were stored in cupboards that patients were meant to keep their toiletries and one cupboard had exposed wires which were a risk. The provider did not have clear plans in place for when action would be taken to address the replacement or maintenance required.

- Patient risks were not always well managed, and staff were not responding to the changing risks of patients. Care plans in Aspen and Lavender ward were not person centred and patients were not involved in the planning of their care although staff had provided them with copies of their care plans. Some records were written using disrespectful language their descriptions showed a lack of understanding of on how to support patients with a learning disabilities and autistic patients. Staff, at times, failed to recognise that some patients showed signs of frustration and anxiety when they were not able to communicate their needs. There was a lack of understanding by some staff on how to manage situations when patients became frustrated because they were not able to express their needs clearly.

- Holistic assessment and an individualised behaviour support plan (or equivalent) were not in place or reviewed regularly in Aspen and Lavender ward. Staff did not have the skills needed to develop and implement positive behaviour support plans. Where positive behaviour plans were in place staff were not reviewing them and they were not consistently followed. Training had not been provided to support staff to implement positive behaviour support plans effectively.

Summary of findings

- Medicines were not managed safely and not all staff had been assessed as competent in administering and managing medicines safely. Staff did not always undertake physical health checks as required following the administration of some 'as required' (PRN) medicines. Staff had not fully completed medicines administration records, patients' allergies were not documented on their medicine charts and charts were not stored according to the providers policy or recognised good practice guidance.

- Staff were not following good practice guidance in relation to minimising the use of restrictive practices. Individual patients' protocols were not in place to consistently administer medicines prescribed to be taken "when required". We found an excessive use of when required medication (PRN) to manage agitation and no plans in place to reduce the use of PRN by adopting other types of intervention. The provider and ward staff were not aware of the national programme 'Stopping Over Medication of People with a Learning disability, Autism or both' (STOMP) and this had not been discussed by the multidisciplinary team.

- Staff lacked an understanding of section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Documentation was not clear on the restrictions attached to patients with section 17 leave agreed by the Ministry of Justice. We found examples of patients going on leave without the appropriate section 17 leave form in place.

- There were a number of blanket restrictive practices in place on the wards without clear clinical rationales and without being regularly reviewed. For example, restrictions and rules included, 'patients must have a tidy room', 'attend to their personal hygiene' and 'attend the morning meetings and activities'. If all patients did not adhere to these restrictions, they were not allowed to have their section 17 leave.

- Accessible Information Standards were not followed. Patients were not provided with easy read information which could help them understand or communicate effectively with support. Not all staff were aware of the specialist needs of patients in their care. For example, patient's communication needs were not identified, and adjustments made on the way information was shared.

- Patients were not provided with lockable storage to keep their possessions safe.

- Patients feedback about activities and opportunities for improving daily living skills was variable. One patient said they found the activities boring and another said they were not able to access the OT facilities as they were not confident using stairs.

- Patients were not able to prepare refreshments and snacks as facilities were kept in the office and they were not given access to this area; another aspect of restrictive practice in place without clear rationale.

- The staff were not supported through training and supervision. Not all staff had completed the mandatory training provided and the provider was not providing appropriate mandatory training to support staff to carry out the duties of the role. For example, not all staff had attended training that increased their insight into how to care for patients with learning disabilities and autism. Some staff were restraining patients without having completed training on how to restraint patients safely.

- While there were sufficient numbers of staff on the wards, not all staff were skilled or experienced in meeting the needs of patients with learning disabilities and autism. Staff did not receive regular supervision and not all staff had an annual appraisal.

Summary of findings

- The culture of the service did not reflect best practice guidance for supporting patients with a learning disability or autistic people. Senior managers and staff did not understand the underpinning principles of Right support, right care, right culture guidance, or how these could be used to develop the service in a way which supported and enabled people to live an ordinary life, enhance their expectations, increase their opportunities and value their contributions.

- Senior leaders did not have a clear understanding of what was required to provide a service for people with a learning disability and autism. They lacked insight into the needs of the patients and were not sufficiently skilled, experienced and knowledgeable themselves to identify what patients needed and what staff working on the wards needed to do to deliver high quality care to patients.

- Senior leaders did not have enough oversight of all the safety concerns and risks. Governance systems lacked clarity and were not robust enough to effectively manage, monitor and aid improvement of services. Systems and processes were not effectively audited and evaluated to ensure effective practice and respond to the needs of patients with protected characteristics.

- Leaders did not have the skills and abilities to run the service effectively. There was a lack of clear clinical oversight of the wards and leaders had little knowledge of what was happening at ward level, including how care was being delivered or the standard of that care. Whilst a risk register was in place this did not reflect all risks found in the service or any means of effectively managing these.

However:

- We found that generally there was the number of registered nurses and support staff on duty on each shift that the provider had identified should be on duty but that's staff did not always have the appropriate skills and experience. Staff told us that sometimes the wards were short-staffed. There were enough doctors on duty.

- Staff understood their role in safeguarding patients and followed the correct procedures when they had concerns.

- Staff assessed patient's mental capacity appropriately. There was a record of whether the patient had capacity to consent to treatment on admission and regularly thereafter, including at each three-month period. There were capacity assessments where there was a reason to believe a patient may lack capacity.

- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

- Patients felt able to approach staff with complaints. However, there was no easy read information on the wards informing patients how to make complaints.

- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, information on the location of emergency equipment was not displayed on the clinic room door in Aspen ward.

- The ward staff worked well together as a team.

- Care plans in Mulberry ward were person centred. However, we did not find this on Lavender and Aspen wards.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Shrewsbury Court Independent Hospital

Shrewsbury Court is registered as a 50-bed independent hospital, situated in Redhill Surrey. It 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.

At the time of the inspection we visited three wards for patients with learning disabilities and or autism

- Aspen Ward for 13 male patients
- Lavender ward for seven male patients. At the time of the inspection the provider had recognised that this ward not fit for the purpose and was due to close for refurbishment; patients would be moved to Aspen Annexe. Following the inspection the provider notified us that patients had been moved to Aspen Annexe and refurbishments had commenced on Lavender ward
- Mulberry ward for four female patients

The service also offers locked rehabilitation services in three other wards

• Maple single sex rehabilitation wards

• Oakleaf Ward recovery and rehabilitation ward.

• The providers took a recent decision to close Fern Cottage

The registered manager, who is also the hospital director, has been in post since 2016.

What people who use the service say

Patients told us they mainly felt safe although they made reference to “bullying” from other patients. This was due to lack of provision to store their possessions safely. For example, storing toiletries and snacks. The provision we saw in Lavender ward was not suitable for patients’ toiletries as we noted cleaning chemicals were stored in one cupboard and paint and exposed wires in another cupboard. This was raised with the ward manager.

Patients told us they were provided with copies of their care plans.

Patients feedback was variable about activities and opportunities for improving daily living skills. They said the meals served was good, but they were not able to prepare their own refreshments as facilities were kept in the office. Comments from patients about how they kept themselves occupied included, “I am bored” “sometimes I go to activities” and access to the occupational therapy room was cause for anxiety as it was on an upper level and not easily accessible for patients.

Patients gave us very negative feedback about the environment. Patients told us they were able to report maintenance repairs directly to the estate’s manager. During the inspection we saw the estate manager acknowledged to patient the repairs they had reported.

Summary of this inspection

Patients told us they were able to approach staff with complaints and they were confident their concerns were taken seriously.

Patients comments about staff were variable. Some said the staff were kind while others made comments about specific staff. For example, blaming them for scribbles on walls. These comments were taken seriously, and action taken by the ward manager.

Carers that gave feedback raised concerns about the staff's lack of understanding and insight into the needs of their loved ones, about over use of "when required" medicines and said that their loved ones often looked "drowsy".

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,

During the inspection visit, the inspection team:

- spoke with the registered manager, clinical medical advisor, medical director and owners
- spoke with three patients during the inspection and we received completed feedback
- spoke with 11 staff members, including ward managers and deputy managers, consultant psychiatrists, consultant psychologist, occupational therapists and, nurses and support workers
- looked at six staff records from across the hospital
- reviewed a number of accident and incident reports and the lessons learnt from these
- looked at quality assurance audits
- looked at a range of policies, procedures and other documents related to the running of the hospital and each of the core services
- visited three wards and looked at the quality of the environment including the clinic and treatment rooms
- looked at eight care records of patients including medications records
- observed the care and support provided and interactions between patients, visitors and staff throughout the inspection
- carers of two patients provided feedback

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take to improve:

- The provider must ensure that risks to the health and safety of patients receiving care and treatment are assessed, monitored and appropriate mitigations are in place, including for fire and ligature risks Regulation 12(2) (a) and (b)

- The provider must ensure the premises used by patients are safe to use, clean and fit for their intended purpose. Fixtures and fittings must be repaired or replaced, and hygiene standards must be improved and maintained. Regulation 12 (2) (d)

- The provider must ensure that it deploys staff, including agency, with the right qualifications, skill and experience to safely meet the needs of patients and should provide training to enable all staff, including agency staff, to fulfil their roles. Regulation (1) 18 - Regulation 12 (2) (c)

- The provider must ensure a positive behaviour support approach is embedded across the learning disability and autism wards to enable effective support and responses by staff to patients whose behaviour may challenge. Regulation 12 (a) (b)

- The provider must ensure the proper and safe use of medicines. This includes ensuring the providers policy and practice reflects recognised best practice around reducing the use of 'when required medicines' (PRN) in line with Stopping Over Medication of People with a Learning disability, Autism or both' (STOMP) and that accurate records are maintained. Staff must carry out physical health checks for patients following the administration of certain PRN medicines in line with best practice. Regulation 12 (2) (g)

- The provider must ensure that staff have the skills to understand, treatment and care for patients in their care in compliance with 1.14 of the MHA Code of Practice. Regulation 11 (4)

- The provider must ensure it provides person centred care that meets the needs of patients and that patients in Aspen and Lavender ward are involved in developing their plans of care. The provider must ensure that reasonable adjustments are made to meet individual patient's communication needs. Regulation 9 (3) (a), (b) and (c)

- The provider must ensure that records promote patient's dignity. The provider should ensure language used by staff to describe patients in records is appropriate, respectful and follows good practice guidance. Regulation 10 (1) (2)

- The provider must ensure patients were provided with lockable storage to enable them to keep their possessions safe. Regulation 10 (1) (2)

- The provider must ensure it operates systems and processes to effectively assess, monitor and mitigate risks relating to the health, safety, and welfare of patients and others and the safe and effective care and treatment provided to patients Reg 17

- The provider must ensure it delivers care in line with nationally recognised best practice and has clear leadership and oversight, including clear clinical leadership and oversight of the risks and all aspects of care and treatment delivery. It must take action to make improvements in a timely manner. Regulation 17 (2) (b)

Summary of this inspection

Action the provider SHOULD take to improve:

- The provider should ensure that in Lavender ward information telling informal patients they are free to leave the service is on display.
- The provider should ensure that restrictions for managing behaviours such as attending to meetings in Aspen ward relate to individual patients and a blanket approach is not taken.
- The provider should ensure staff have the opportunities for supervision to discuss performance and training needs and should ensure staff have annual appraisals.
- The provider should consider the how access for making refreshments is to be given to patients.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Wards were not safe, clean, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Patients were placed at potential risk of harm. The inspection team had to ask the provider to remove obvious and significant ligature anchor points on the first day of the inspection. For example, broken brackets, information racks, exposed pipe in bedrooms and door closures. The ligature risk assessment lacked clarity on how staff could reduce the risks. Although the ligature risk assessment identified the severity of risk posed by the various ligature points, the risk management plan was not realistic or measurable. For example, two staff were deployed to work in Lavender ward and despite the level of risk being rated as high/medium the staff were to undertake half hourly checks of seven bedrooms, the quiet lounge, corridors, the lounge, dining room, and garden, which would normally be the response if risks were rated as low.

The risk assessment dated 30/06/2021 showed that little progress had been made from the risks identified on the one completed on 29/05/2021 and did not include a time frame for completing the actions. For example, the level of risk in the risk assessment for the information rack in Lavender ward conflicted with the multidisciplinary team (MDT) meeting. While the information rack was identified as an imminent risk at the MDT meeting due to the potential for self-harm, the May and June 2021 risk assessment had rated it as posing a low risk because staff were present in the area at all times. We noted that the information rack was no longer in use and staff were not always present in the area. This meant the risk had increased to patients who may self-harm. In the quiet room we also noted a broken bracket with sharp edges and screws which could be have been used as ligature anchor point. The information rack and broken bracket in the quiet room was removed once we had escalated the risk to the registered manager.

Fire risk assessments had been completed for all wards. However, senior managers had not ensured the identified risks were removed or reduced. The May 2021 fire risk assessment stated that fire compartmentation was not fully effective

across the premises and there were "excessive gaps between fire doors and door frames." The risk assessment also stated that the remedial action taken by the provider was not effective. Fire doors were not included on the risk register and the provider's action plan documents did not address the identified risks. Senior leaders lacked oversight of what actions had been taken to address these concerns.

Since the inspection the provider has had another fire risk survey carried out. The fire safety consultants had identified a number of areas for remedial action. The report identified that replacement fire doors were not installed to an acceptable standard and were identified for upgrade. However, we were not assured that the timeframe for the upgrade of fire doors was appropriate as this was due to be done by November 2021 which left a considerable risks for patients and staff as minimal mitigations would be in place until the upgrade had been completed. During our regular monitoring, following the inspection, we have been told by the estate staff that the fire doors have been audited and that an action plan would be implemented imminently.

Maintenance, cleanliness and infection control

There were parts of the property that were not clean, well maintained, well furnished and fit for purpose. Designated staff told us Infection and Prevention Control (IPC) and hand hygiene audits were taking place regularly. However, the audits had not identified all the issues with cleanliness and infection control that we found on inspection.

There were fixtures and fittings in need of repairs across all wards and parts of the property were not to a good standard of cleanliness. There were dirty marks on internal doors and walls and some doors were damaged.

On Aspen ward a strong smell of urine hit you on entering the ward. One patient complained that their bedroom en-suite had unpleasant odours and we found the staff had used tape to seal the edges of the door to try block the smell.

When we visited the garden on Lavender ward there was litter such as plastic wrapping, medicine cups and black sacks strewn around. There were old dried tea bags thrown on the walls by a previous patient which had not been removed or cleaned. There were broken pavement slabs which posed a risk for falls. We escalated this to the hospital director who had the litter removed the following day.

In Aspen ward there were four boarded up windowpanes, there was damage to the counter in the lounge and there was mould in the courtyard which may be harmful to patients with respiratory conditions. We asked staff how long these had been damaged and they said they had been damaged for over a month.

In Lavender ward internal doors were damaged, fire extinguisher boxes were empty without signpost to the alternative location of fire extinguishers, the hot water tap in the dining area was hanging off, the fridge in the lounge, that was for the use of patients, was out of use, the sofas were split or had missing legs. We saw that previous patients had scrawled on walls, including in bedrooms but this had not been removed before new patients had been admitted. The maintenance plan was presented as a list of tasks and lacked measurable actions, timeframes for completion and an identified responsible member of staff to complete the actions. Following the inspection, estates staff have told us they would be joining the ward manager on environmental audits to ensure they know what action needs to be taken

The wards provided single sex accommodation. The layouts of the wards allowed all parts to be observed and, where appropriate, mirrors were used in corridors to remove blind spots.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Inadequate

Wards for people with learning disabilities or autism

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Emergency medicines were sealed and date that medicines expired was recorded. However, information on the location of emergency equipment was not on display on the door of the clinic room in Aspen ward.

Staff checked, maintained, and cleaned equipment.

Safe staffing

Nursing staff

The provider was taking steps to recruit staff to vacant posts. Agency staff were used to maintain the staffing levels that the provider had identified as being adequate to provide care. The ward manager for Mulberry and Lavender wards made the decision to have regular agency staff working on the wards when they could.

Although staff said staffing levels were mostly maintained they also said there were times when wards were short staffed. Ward managers had not ensured that the staff on duty had attended training in managing behaviours deemed to be challenging and in Immediate Life Support.

There were arrangements for patient to have one to one sessions with their named nurse. In Lavender we saw that the named nurse designated to provide one to one support to specific patients was on display

Medical staff

The service had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency. Patients had access to medical staff 24 hours a day. The medical director told us the team worked office hours and there was an out of hours on call system covered by the medical director and two consultants.

Mandatory training

The identified mandatory training programme was not sufficient to ensure staff had the skills to carry out the roles to meet the needs of patients in Mulberry, Lavender and Aspen - learning disabilities and autism wards. The training records for August 2021 showed the service had missed the target of 85% of staff completing all their training. For example, attendance at fire training was 72% and First Aid was 62%. We were not reassured that staff had gained the level of skills needed to provide immediate emergency support.

The figures on the training matrix provided by the hospital director showed conflicting and inaccurate information. For example, the matrix showed that in July 2021 seventy three percent of staff had completed Immediate Life Support (ILS) training with 66% having completed this training in August 21. When we calculated the figures based on the number of staff that had attended as a percentage it came out as 52%. This meant that staff with skills in Life Support were not always on duty which placed patients at potential risk of harm.

Although the service had changed three wards to provide care and treatment to patients with learning disabilities and autism who also had mental health needs not all staff had attended the training necessary to meet the complex needs of patients.

Inadequate

Wards for people with learning disabilities or autism

We were not assured that there were enough staff with the experience and skills needed to meet the needs of patients with learning disabilities and autistic people. For example, on Aspen ward only 46% of staff had completed the Certificate in Working with People with Learning Disabilities and only 33% had attended more in-depth training in understanding autism.

The matrix also identified that only 60% of all staff on the learning disability and autism wards had attended dual diagnosis training and only 5% had completed Mental Health Act Level 1 and 2 training. Seventy five percent of staff on others, except Aspen, had completed the learning disability basic principles training.

Low numbers of staff had attended training on how to manage situations when patients' behaviours placed them and others at risk of harm. Only 50% of staff had attended Breakaway training and only 45% of staff had attended the two day Management of Violence and Aggression (MVA) and (Prevention Management of Violence and Aggression (PMVA) training.

Mandatory training was on the providers risk register. However, this did not provide sufficient detail on what the provider was doing to improve attendance at training. During the inspection we escalated the lack of PMVA and ILS training to the senior leadership who were unable to provide us with a detailed action plan of when they expected the majority of staff to have completed this training in line with the providers training target.

When we reviewed the training matrix, we noted that staff were attending multiple courses on the same day. For example, some staff attended four courses in one day and one member of staff completed 10 courses in one day. Although the provider sent us the contents of some of the courses we still had concerns about whether the courses, delivered in this manner, provided staff with adequate knowledge and skills to do their job effectively. We found that there was little opportunity for staff to discuss what had been covered on the courses, that competencies weren't checked and therefore learning was not embedded in practice.

Assessing and managing risk to patients and staff

Risks were not always assessed fully or robustly. The details in the risk assessment were variable. Staff used restraint as a last resort. The provider had a restrictive interventions reduction policy in place

Assessment of patient risk

Risks to patients were not fully identified and staff were not always responding to changing risk. Staff used a recognised risk assessment tool such as the National Early Warning Score (NEWS2) charts. The NEWS2 document supports early warning of when a patient has deteriorating physical health. Sixty six per cent of staff had attended training about NEWS2. However, NEWS 2 scores were not consistently documented and follow up assessments were missing for some patients where a high score, should have led to escalation and action being identified to address the physical health issues.

Staff used the behaviour support plans that patients had come with from their previous placements/hospitals and did not update these as needed The care plans and risk assessments were not always linked to each other and staff did not review or adjust the support plans during the patients admission to the hospital. This resulted in a number of behaviour support plans being used which were not always reflective of current support and care needed. The provider acknowledged that, because training had not been provided, some staff were not as knowledgeable as they needed to be on how to review behaviour support plans.

Inadequate

Wards for people with learning disabilities or autism

We reviewed eight behaviour support plans on Lavender and Aspen wards. The plans did not include all the identified risk from the Violence and Risk Assessment Scheme Revised (HCR-20) and the Short Term Assessment of Risk and Treatability (START) assessments. For example, for one patient the managing aggression care plan stated no incidents of violence or aggression had been reported. However, START risk assessment identified the patient had a history of violence and aggression.

Managing "my mental health" plans were in place for three patients in Aspen ward. However, the action plan was not linked to other areas of risk. For example, how to reduce the risk when there were signs of deterioration in mental health needs and how to support the patient to manage the challenges with their mental health.

Management of patient risk

Where risks were identified staff were not consistently responding to the risk in line with support plans. For example, meaningful engagement was identified as an objective for one patient in their PBS plan. The guidance was for staff to use a "STAR" chart to achieve the outcomes of providing additional activities and community visits. Restrictive intervention for the same patient included the use of a quiet room or use of seclusion as a last result**.** However, staff were unaware of a "STAR" chart for this patient so additional activities and community visits weren't always provided. Seclusion for the purpose of preventing patient's from leaving the room was an option in the care plan although this facility was not available at the hospital for the patient.

Staff were not clear on their roles in relation to each patient's support plan or the person-specific protocols for addressing behaviours, this placed patients at risk of harm. Behaviour support plans were not clear, detailed or used by all staff. During the inspection we observed staff managing situations which placed patients at risk of harm due to their behaviours. We noted that some staff were not following the PBS plan and were not offering one to one support, using a communication book, or using a non abrupt approach as identified. The PBS from the previous placement was being used and identified that staff should use a communication grab sheet and where risk escalated to use Management of Actual or Potential Aggression (MAPA). However, staff were unaware of a communication grab sheet and MAPA was not one of the interventions used at the hospital.

Use of restrictive interventions

The Restrictive Practice policy dated January 2021 was not embedded into practice. The policy described the least restrictive practices and interventions approach to be used and listed medicines where sedation occurred as an example of restrictive practice.

The medicine policy was not embedded into practice. The use of medicines prescribed to be taken "when required" (PRN) for "agitation" was not reviewed to ensure least restrictive practice and interventions. Documentation showed patients in Aspen Ward were repeatedly administered "when required" (PRN) medicines to manage "agitation". In the period between April and August patients were administered with PRN Lorazepam (used to treat anxiety disorders,) up to 114 times and Promethazine (used to treat anxiety**)** up to 70 times. There was no plan in place to reduce the use of PRN medication for agitation to other more appropriate care and treatments.

Staff were not provided with the right information or guidance to safely administer medicines such as sedatives prescribed "when required" (PRN). Individual PRN protocols were not in place on when it was appropriate to administer "when required" medicines prescribed which included the signs of agitation by reducing the harm of inappropriate psychotropic drugs which are used as a "chemical restraint" in place of other more appropriate care and treatments

Inadequate

Wards for people with learning disabilities or autism

The Stopping Over Medication of People with a Learning disability, Autism or both (STOMP) project is a national project to help prevent the overuse of medications. The provider was not aware of this and this did not have a STOMP action plan or self-assessment in place at the time of the inspection. The medical director had an understanding of STOMP but this was not discussed as part of clinical governance despite the provider being a learning disability service.

The providers policy states that all staff should be trained in the Human Rights Act, Mental Health Act and Mental Capacity Act.

Some records were written using disrespectful language. For example, A patient was described as having "mild mental retardation." In Lavender ward we noted that some care records described patients as "difficult", "demanding and behavioural" and "pushing boundaries". These descriptions showed a lack of understanding on how to support patients with a learning disabilities and autism. Records lacked detail on the boundaries the patient was adhere to or how staff were to respond when they were "pushed."

Medicines management

The service used systems for the management of medicines.

The medicine policy dated June 2020 stated that the designated managers and staff involved with supervising or administering medication should attend a training programme on the safe use of medicines and be assessed as competent in medication related tasks. However, at the time of the inspection, not all relevant staff had their competencies checked before administering medicines. We found one example where a staff member had not had their medicines competencies signed off before dispensing medication. The hospital director informed us that this staff member had only dispensed medication on the first day of our inspection. However, when we requested to see the prescription records, we found this staff member had dispensed medication on multiple occasions in August 2021. When we raised this, the hospital director stopped the staff member from giving medicines. Following the inspection, the providers gave assurance that all new and existing staff competencies had been checked to administer medicines.

The provider used an electronic medicines record system, but staff told us this often failed and they had to transfer the details of patients medicines onto paper records. Staff then disposed of the paper copies meaning that there were no accurate records kept of the medicines that had been given or who had given them. This was not in line with the providers policy or best practice which identifies that accurate records should be kept. This posed significant risks as patients could potentially be given too much or too little medicine. Staff were also not reporting the electronic system failure as incidents and there was no process in place to check that the system worked so the senior leadership was unaware of the problems with the electronic system.

The providers medicines policy did not provide staff with guidance on administering medicines that required physical health checks, so staff were not undertaking physical health checks following the administration of some PRN medications and putting patients at risk.

Staff were not following best practice guidance for recording and for administering PRN medicines. They were not provided with the right information on how to safely administer PRN medicines prescribed for agitation and for pain relief. Individual protocols were not in place on how staff were to administer them as intended by the prescriber.

Where PRN pain relief was prescribed individual protocols were not in place on the maximum dose to take in a day, the minimum interval between doses, the side effects and where more than one "when required" medicine was prescribed for the same condition the order for administration. Since the inspection the providers have confirmed protocols were to be introduced

Staff did not record a patient's allergy status in any of the documentation relating to medicines administration despite the patients hospital passport having these details recorded. This was not in keeping with national guidance and could lead to a patient being the administered a medicine that they were allergic to which could result in the patient experiencing severe side effects.

Staff access to essential information

Patient's notes were not always detailed and comprehensive. Care plans lacked guidance to staff on how to deliver care and treatment which met individual patient's needs. For example, we found that recommendations in the Community Treatment Review (CTR) report to complete sensory plans was not actioned by the ward staff.

The service used a combination of electronic and paper records. Agency staff were not provided with the ability to log into electronic records. On both days of the inspection the two staff on duty in Lavender ward were agency staff. These staff told us that although they did not have access to computer records the handovers that they received when they came on duty were used to update them on patients changing needs.

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 on how to recognise and report abuse, appropriate for their role. The training matrix provided showed that 88% of staff had attended the training.

Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them. They knew about the types of abuse and their responsibility to report poor practice which they may witness from others.

Staff made safeguarding referrals when patients were cared for in long term seclusion.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents, although not all incidents were being reported. Managers investigated 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.

Incidents were reported by staff through an electronic reporting system. Incidents were reviewed at the monthly risk management meeting which the medical director chaired.

Inadequate

Wards for people with learning disabilities or autism

Staff told us that they received debriefs following incidents. Clinical staff attended training on investigating serious incidents. They said investigation reports were prepared and these were shared appropriately with staff. Lessons learnt were detailed and shared during meetings across the hospital site. For example, following a death which related to refusal for physical health checks, practice had been changed. Staff were now to carry out mental capacity assessments when patients refused interventions, and this had been embedded as part of everyday practice

However, staff were not reporting all types of incidents. For example, when the electronic prescription system failed this was not reported as an incident, and senior leaders were not aware of staff using hand written documents to dispense medicines.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Skilled staff to deliver care

The staff in Mulberry, Aspen and Lavender did not always have, or display, the skills and knowledge and competence to meet patient's needs. Staff generally lacked the right and understanding of the needs of patients with learning disabilities and autism. Not all staff in these wards had attended awareness training in learning disabilities and understanding autism although it was part of the mandatory training. The hospital's training matrix showed that 75% of staff across Lavender and Mulberry had attended this awareness training. The staff in Aspen ward were to attend specifically designed training to meet the needs of patients with learning disabilities and understanding autism. The training matrix provided showed that46% had gained a certificate in Principles of working with patients with Learning Disabilities and 33% had the Level 2 Certificate in understanding Autism. While 60% of staff had attended understanding behaviours that challenge.

Although learning disabilities training was mandatory for staff in Aspen Ward, the outcome detailed in minutes of the clinical ward manager meeting dated July 2021 was to advise a member of staff to attend the training when they raised concerns about managing incidents where patient's behaviours placed themselves at risk of harm. The head of psychology told us that to support development, mentorship was to be part of the two day training programme but this training was not yet implemented

The Aspen clinical ward manager governance meeting minutes dated July 2021 made reference to an increase in violence and aggression incidents. It was documented that there were nine incidents of violence and aggression, two of self-harm and eight where there was damage to property. However, staff were not trained to manage behaviours where patients placed themselves and others at risk of harm. For example, only 20% of staff had attended understanding behaviours deemed to be challenging, and 50% had attended breakaway training.

Staff were not consistently supported through line management supervision to discuss performance and developmental needs. On Lavender and Aspen 75% of staff had received supervision but only 12% had received an annual appraisal in 2021. Senior managers supported medical staff through general supervision of their work. Medical staff accessed their own clinical supervision and appraisal outside of the hospital.

Managers gave each new member of staff an induction to the service before they started work. Agency staff told us their induction included a familiarisation of the building and an introduction to patients on the ward.

On both days of the inspection two agency staff were rostered to work on Lavender ward but only one had experience or had attended training on learning disabilities and understanding autism

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

Only 5% of staff had attended training on the Mental Health Act and the Mental Health Act Code of Practice although staff had a general understanding of patients' legal position and rights under the MHA and explained, as required, patients' legal position and rights under the MHA

However, staff lacked an understanding of section 17 leave (permission to leave the hospital) agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff allowed patients to have more leave than had been agreed which meant they were out of hospital outside of a legal framework. Records showed that two patients on Aspen ward went on leave when the section 17 had expired. Documentation was not clear on the restrictions placed on patients with section 17 leave agreed by the Ministry of Justice. There was a lack of information on how the service ensured that staff were aware of the restrictions and relevant authorisations placed on patients by the Ministry of Justice.

Information about independent mental health advocates (IMHA) was available in Aspen ward. Patients who lacked capacity were automatically referred to the service. There was no information displayed in the ward about the role of Care Quality Commission (CQC), how to make a complaint or the right to see an Independent Mental Health Advocate (IMHA) services were available in the hospital seven hours per week. The IMHA said that this was enough given the low number of patients currently being admitted. We were told that the advocacy service would attend the ward at other times when requested. The advocate spoke to all new patients following admission.

On Lavender ward information there was no information on display letting informal patients know that they were free to leave the wards if they wished to. The ward manager told us a noticeboard was to be ordered where information for informal patients would be displayed.

Patients told us that they were not involved in planning their care. They told us that they had a care plan, but that this were prepared and given to them by staff. Care plans were generic and not person centred.

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.

Seventy seven percent of staff had attended Mental Capacity Act and Deprivation of Liberty Safeguards training and their understanding and application was consistent with their role.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed capacity appropriately. There was a record of whether the patient had capacity to consent to treatment on admission which was reviewed regularly. Patients mental capacity to make specific decisions was assessed to ensure they had capacity to make decisions in relation to physical health and medication.

There were capacity assessments in place when there was a reason to believe a patient may lack capacity, relating to other decisions a patient may be required to make, including in relation to physical health medication.

Assessment of needs and planning of care

Referrals for admission came to the ward manager from the hospitals business development manager. Care plan proposals were devised for placement referrals to the hospital. A ward manager told us ultimately, they made decisions regarding patient's compatibility for admission to their ward.

Physical health risk assessments were completed, and the action plans listed the actions to achieve the outcomes identified.

The two patients in Mulberry ward were involved in personalising their care file which reflected their individuality and they were aware of the content of the care records. The ward manager had introduced personalised care planning as a project. The care records detailed the patients preferred first name and some of their handwritten notes. A help sheet on 'how to engage with the patient', gave examples such as making jokes, assuming an upbeat mood, drawing in colour, activities the patient enjoyed and gave other tips on the best ways to engage with the patient.

The staff in Aspen and Lavender ward lacked an understanding of how to develop individually person-centred care plans to provide detailed guidance on how they were to manage situations from escalating when signs of anxiety and frustration were presented and, including making changes to the environment and a focus on skills development. Care plans in Aspen and Lavender ward lacked patient's preferences and action plans lacked detail on how to meet the identified needs. The recovery plans for patients just detailed a list of actions that didn't have any detailed guidance on achieving the outcome. For example, a patient in Lavender was described in their 'managing their mental health' section of the care plan as "demanding, will get irritable if his demands [are not met] and will be irritable if his demands are not met immediately" However, the action plan lacked detail on how to respond to the requests. The medical director told us it was possible the staff didn't always have time to read, review and understand care plan.

Care and Treatment Reviews (CTRs) were organised by the respective commissioners for people with a learning disability. Recommendations made during the reviews were included in the reports. However, on Aspen ward we saw that previous recommendations made at a CTR had not been actioned. For example, the recommendation was to develop physical health care plans and add details such as photographs to missing persons procedures, but this had not been done.

Best practice in treatment and care

The hospital had recently recruited a number of specialist therapists to provide a range of treatment and care for patients based on national guidance and best practice but it was still early days However, plans included providing access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff took some steps to support patients with their physical health.

Staff used recognised rating scales to assess and record severity and outcomes.

Staff developed physical health risk assessments to identify patient's health care needs. For example, epilepsy, diabetes and asthma. This was meant to result in an action plan being developed to address the identified needs. However, staff did not always document health checks consistently. For example, when patients needed weekly weight checks.

Inadequate

Wards for people with learning disabilities or autism

The hospital had recently recruited a number of specialist therapists to provide a range of treatment and care for patients based on national guidance and best practice but it was still early days The team included occupational therapists (OT) and had recently recruited a dietician and speech and language therapist (SALT). We were told of the dietician and SALT was a recent one and they were going to introduce communication plans.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients were assessed by the OT who then developed individual timetable to support each patient's needs, such as literacy and numeracy, fitness and open sessions in the afternoon for group and individual games such as PlayStation video games.

Patients were to have access to the recently recruited clinical psychology team who would provide psychological therapies. Drop-in sessions were to take place for the team to familiarise themselves with the patients and to make patients aware of what they would be doing. The role of the psychology team was going to include assessments of patients, delivery of short term treatment and to run groups.

Patients had access to NHS facilities such as dental and optician; visits were organised to the service if the patient could not attend.

Multi-disciplinary (MDT) and interagency 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. MDT meetings were weekly, they had a set agenda and were attended by the medical advisor (non- clinical role to improve and change) clinical staff, the hospital director and partners. Staffing, recruitment and discharge decisions were standing agenda items at the MDT meetings.

Are Wards for people with learning disabilities or autism caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Some staff treated patients with compassion and kindness. Patients' privacy and dignity was not fully respected.

Staff were not following good practice guidance to support patients to communicate in a way they were able to understand. We saw staff become confrontational and argumentative over situations that were avoidable if staff had an adequate understanding of the needs of patients with learning disabilities and autism. For example, during the inspection we observed staff in Lavender ward refuse a patient juice to drink, no explanation was provided for their

decision, they did not offer an alternative or explain when juice drinks would be offered again. Further evidence of poor understanding was demonstrated by staff using derogatory language in records to describe patients. For example, patients were sometimes described using derogatory language such as "behavioural" "difficult", "demanding" "pushing boundaries". However, we also saw some staff actively and positively engage with patients.

Patients in Aspen ward told us that staff treated them with dignity and respect and met their needs. However, we saw physical health checks being carried out in the communal areas of the ward, which compromised patients' privacy

Patients did not have keys to their bedrooms. There was no space in bedrooms with lockable storage to store personal items and keep them safe

Patients could not make their own drinks when they wished. Refreshments making facilities such as the kettle, fridge and microwave were kept in the office and patients were not given access. We saw patient request a variety of refreshments and staff responded to their requests

Patient information was not always kept confidential. We saw paper records of medicines with patients' names clearly identified being placed in an open bin under the desk in the office or labelled for shredding. This bin was not a specialist bin for shredding and compromised privacy.

A patient in Mulberry told us that "staff were nice and kind" and we observed these staff use a gentle and kind approach towards one patient.

Involvement of patients

Patients had access to their care plans and risk assessments. Patients told us they were provided with copies of their care plans and had one to one time with a keyworker but were not involved in developing their care plans.

Patients could give feedback on the service and their treatment and staff supported them to do this. A suggestion box was available at the service for complaints and compliments. Surveys to gain patient feedback about the service had been conducted and 21 responses had been received. An action plan was in place which identified improvements needed from the feedback received. Examples of action that had been taken as a result of feedback included that patients should be provided with copies of their care plans and welcome packs were to be introduced and had to include copies of the complaint's procedure.

Involvement of families and carers

Staff informed and involved families and carers appropriately through MDT meetings. Carers gave feedback that remote MDT meetings were challenging. They said care and treatment decision made at the MDT were not clearly communicated to them.

Are Wards for people with learning disabilities or autism responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Inadequate

Wards for people with learning disabilities or autism

Access and discharge

Staff planned discharge with commissioners and external professionals of services

Bed management

Managers made sure bed occupancy did not go above 85%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Discharge and transfers of care

The medical director told us the service had clear discharge pathways. Clinical staff told us that decisions about discharges were made at MDT meetings which included commissioners and care coordinators from the patients local team.

Staff did not always clearly document patients discharge plans. We reviewed eight care records and only two had discharge plans.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom

Each patient had their own bedroom, which they could personalise. However, on Aspen and Lavender wards patients were not provided with a secure place to store personal possessions.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The service had outside space. All wards had access to a small outside courtyard which patients accessed with supervision and at the staff's discretion. Some were not well maintained. For example, there was uneven paving and litter strewn around that hadn't been cleaned up for some time.

The service offered a variety of good quality food. Patients told us the meals served at the service was good. However, we saw an instance in Mulberry ward where a patient was not given refreshments when requested.

Patients' engagement with the wider community

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

Patients had access to occupational therapy (OT) and they had had access to opportunities for education and to develop daily living skills such as preparing meals, road safety and budgeting. During the inspection we saw patients having open sessions in the afternoon for leisure activities such as playing on a games console.

Inadequate

Wards for people with learning disabilities or autism

The OT prepared individual timetables for the patients. For example, patients were offered literacy, numeracy and employability work skills.

The OT told us some patients preferred not to join in with activities. Two patients told us that although there was a timetable, they would prefer more activities on the ward.

Meeting the needs of all people who use the service

The service had not made the adjustments needed for patients with specific communication needs. Communication aids recommended from previous placements and professionals were not available on the wards. Four of the eight care records viewed on Aspen and Lavender wards detailed the specific communication needs of patients. However, the resources needed to meet these needs were not available to staff. For example, the provider had not used pictures or symbols on Lavender and Aspen ward to help patients understand their environment better, such as pictures of the garden to show where this was.

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.

Information on how to raise complaints and concerns was on display in the main reception of the service. The procedure included the actions that patients and relatives should take if they were not satisfied with the response or the outcome from their complaints. However, the reception area was not easily accessible to patients and the procedure was not displayed for patients in all wards or in an easy read format.

Ward managers investigated informal complaints and the hospital director was involved in more complex complaints. Complaints were acknowledged within 24 hours and a response followed after the 25 day investigation period. During the inspection one patient raised two concerns and the ward manager took their concerns seriously and instigated an investigation.

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

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leaders did not have the skills and abilities to run a service that provided high quality and sustainable care.

The service was not meeting the principles of Right support, right care, right culture guidance. Senior leaders were not able to provide evidence that they were providing appropriate, person-centred care, that was inclusive, met patient's needs, promoted choice and independence

At the time of the inspection there was no clinical services manager in post so responsibility for the clinical leadership of the service fell to the hospital director and medical director. Clinical oversight of the learning disability wards and knowledge around the challenges the service faced in relation to quality and sustainability was poor. The service had

changed three of the wards from providing rehabilitation/long stay care to providing learning disability services over the last 12 to 18 months. However, the provider had not suitably prepared the environment appropriately and had nt supported staff to develop the right skillset to ensure they were able to care for patients with learning disabilities and autism in a safe and effective way.

The senior leadership team included the hospital director, medical director and hospital partners. Only the medical director had a background in learning disability services and the senior leaders did not have a clear vision for the service for people with a learning disability and autism. They lacked insight into the needs of the patients and into the skills, experience and knowledge required to deliver the service to meet their needs. However, senior leaders did recognise the patient group would require them to slowly develop the service and make improvements and that delivering a learning disability and autism services might impact staff retention.

At a ward level there were very few staff trained and experienced in working with patients with learning disabilities and autism. One of the ward managers had no background or experience of working with patients with a learning disability. However, the newest ward manager was a registered learning disability nurse but had only been in post for around four weeks prior to our inspection.

Despite staff telling us the partners and the hospital directors were approachable, that they provided good support and were seen around the service, these leaders had failed to recognise the issues with the environments; they had missed the visible signs of repairs needed and the lack of cleanliness in wards which we noted during the inspection. There was also a lack of recognition and oversight of some of the risk we identified during the inspection.

The providers had introduced routine lunches with staff groups such as psychology team. The aim was to provide an informal environment where staff can express their opinions freely.

Clinical staff told us that while improvements were needed the staff were working towards achieving the same goals. They said relationships was good within teams. We were told the senior leadership team including partners and hospital directors were committed to the care of patients. Staff felt their advice and comments was taken seriously by the partners and acted upon.

Governance

The service did not have systems in place to improve service quality systematically and safeguard high standards of care by creating an environment for excellent clinical care to flourish.

There was a lack of robust governance systems and processes in place with a lack of clarity about how these should operate and how they provided assurance. There were a number of management meetings that took place, including clinical governance, multidisciplinary team meetings (MDT), risks management and quality improvement meetings. However, these meetings were ineffective in relation to how they interacted with each other and how the desired outcomes were achieved. The medical clinical advisor (with a non-clinical role to improve and change) said the management meetings were high level strategic discussions where decisions were made on admissions, issues of concern, marketing and business development with partners, business manager and hospital director.

Systems and processes were not effectively audited or evaluated to improve practices which promoted patients' rights and safety. For example, HR practices, robust risk register's, maintenance plans for the service, fire safety systems and safe systems of medicine management.

Inadequate

Wards for people with learning disabilities or autism

The actions identified at the clinical governance meetings for May, June and July 2021 were not consistent with the findings of this inspection. It was reported in the clinical governance meeting on July 2021 that work from estates was pending but on inspection we found that required action had not been taken. All areas that needed repairs or replacement were not identified for action. The environment was in need of significant attention and the poor standards of the ward environment seen during the inspection were not clearly known to the senior leadership team. The required actions detailed in the fire risk assessment had not been fully actioned.

Care plans were to be developed and implemented for patients frequently ordering "take aways" and for weight gain but we did not see that these had been actioned. The care plans seen in Lavender and Aspen ward were not person centred and behaviour support plans from previous placements were in use and not adjusted to meet the patient's current needs.

The psychology team had identified, at the clinical governance meeting, that training in positive behaviour support (PBS) was needed. However, there was no action to address this included in the minutes of the meeting and no action had been taken

There was a lack of oversight and poor risk management of medicines. For example, restrictive practice, excessive use of PRN medicines with no plan to reduce these by following national guidance and a lack of audits for rapid tranquilisation including physical health monitoring post rapid tranquilisation. Medicine management audits were not identified for discussion at the clinical governance meeting in May, June or July 2021.

There was evidence that staff were not following medicine policies such as checking staff's competencies prior to dispensing medication to patients. We found an example of a new staff member dispensing medicines on multiple occasions without any competency assessment in place. We found an example of one staff member dispensing medication from hand written notes and a second using paper records and throwing them into the general waste after use. The hospital director informed us, post inspection, that hand written records were usually shredded by staff. This went against the providers own policy which stated they should be stored and was also not in line with good practice

The leadership team had provided no medicine protocols for "when required" (PRN) medicines which meant that individual protocols were not devised for PRN medicines. There was no audit in place around the use of PRN and the leadership team lacked awareness that nationally recognised good practice in learning disability and autism services was to adopt the Stopping over medication of people with a learning disability, autism or both (STOMP) project when assessing their prescribing of both PRN and other medications.

Carers had an on-line monthly meeting with the MDT and the registered manager. Carers gave feedback that remote MDT meetings were challenging. They said care and treatment decision made at the MDT were not clearly communicated to them.

The provider sought the feedback of patients and had developed an action plan. However, survey responses were not discussed at the governance meeting although an action plan was in place. For example, environmental cleanliness was identified as an issue in 2020 and 2021 surveys, but no action was taken from this feedback

Management of risk, issues and performance

The service did not use systems to manage performance effectively. They did not effectively identify and escalate relevant risks and issues and identify actions to reduce their impact.

Inadequate

Wards for people with learning disabilities or autism

There was a lack of clear clinical leadership and oversight of the current risks within the service. We reviewed the services risk register and whilst there were some items identified on the risk register, they did not reflect all risks that we identified whilst on inspection and so it was clear that the risk register did not provide a comprehensive overview of all the risks at the hospital. We also found examples of risks being identified and not actioned and there was a lack of detail around what mitigations were in place to reduce the risk to keep patients safe. For example, the fire risk assessment identified various concerns with fire doors in the building. When we spoke to senior leaders, they could not provide an update on where the service was in relation to addressing the risks. We were told this was the responsibility of the maintenance manager. However, it meant there was a lack of oversight from senior leaders around how that risk was being reduced. The risk register also provided no information about what actions were being taken to reduce this risk.

Risk that had been identified on the risk register were rated as either moderate or low risk. The risk register was not a reflection of the findings from the inspection. We escalated a number of ligature risks for immediate action on the first day of our inspection along with some maintenance issues that had not been identified or detailed on the risk register. Mandatory training was below 85% target that the provider had set itself and the pandemic given as was the rationale for courses being poorly attended. For example, only 5% of staff had attended the Mental Health Act training course. There was also little information on what the provider was going to do to improve attendance at mandatory training and no dates for when they expected to staff to have completed it.

The provider conducted infection prevention and control audits every three months. However, the audit result we reviewed did not reflect the concerns about cleanliness at the service that we found during the inspection.

Information management

Managers engaged actively with other local health and social care providers. A representative from the Clinical Commissioning Group (CCG) told us the staff were knowledgeable and provided a consistent service to patients. They said the staff were always available to facilitate their visits

Vision and strategy

Staff told us that they were aware of the service transforming to providing care and treatment to patients with, learning disabilities and autism. A member of staff told us there had been a consultation period with the hospital director and partners. This member of staff said there was a “new vision” and staff had needed support while they transitioned. Despite there being a transformation plan in place the provider had not prepared the environment or the staff appropriately to provide care for patients with learning disabilities and autism in a safe and effective way. Training in learning disability and autism was poor and most staff did not have a background in working with patients with learning disabilities or autism.

The values of the service were displayed in the main reception. The mission statement was to ‘peruse excellence in the provision of holistic and evidence based care and treatment to all service users and residents where they are placed at the heart of everything we do’.

The providers told us they were considering re-applying for accreditation with “Investors in People”, which is a framework of standards to measure how effectively a provider invests, supports, develops and manages its workforce.

Culture

Inadequate

Wards for people with learning disabilities or autism

Staff felt respected, supported and valued and they felt comfortable with speaking to managers about issues. Staff told us that although there was no clinical lead in post the ward managers or the hospital director could be approached if they needed support.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care A person centred approach to meet patients individualised care needs was not in place in Aspen and Lavender wards. Patients in Aspen and Lavender wards were not involved in developing their plans of care. The provider had not ensured that reasonable adjustments were made to meet individual patient's communication needs. Regulation 9 (3) (a), (b) and (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Risks to the health and safety of patients receiving care and treatment was not assessed, monitored and appropriate mitigations taken including for fire and ligature risks Regulation 12(2) (a) and (b) • The premises used by patients was not safe to use, clean and fit for their intended purpose. Fixtures and fittings were in need of repair or replacement, and hygiene standards were not maintained to a good standard. Regulation 12 (2) (d) • The staff including agency were not deployed with the right qualifications, skill and experience to safely meet the needs of patients. They were not provided with appropriate training to enable all staff, including agency staff, to fulfil their roles. Regulation (1) 18 - Regulation 12 (2) (c) • Positive behaviour support approach was not embedded across the learning disability and autism wards to enable effective support and responses by staff to patients whose behaviour may challenge. Regulation 12 (a) (b)

This section is primarily information for the provider

Requirement notices

- Medicine systems were not safe. The providers policy and practice was not reflective of recognised best practice around reducing the use of 'when required medicines' (PRN) in line with Stopping Over Medication of People with a Learning disability, Autism or both' (STOMP) and that accurate records were maintained. Staff must were not carrying out physical health checks for patients following the administration of certain PRN medicines in line with best practice. Regulation 12 (2) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patients records did not promote their dignity. The provider had not ensured language used by staff to describe patients in records was appropriate, respectful and followed good practice guidance. Regulation 10 (1) (2) Patients were not provided with lockable storage to enable them to keep their possessions safe. Regulation 10 (1) (2)

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 had not ensured they were operating systems and processes to effectively assess, monitor and mitigate risks relating to the health, safety, and welfare of patients and others and the safe and effective care and treatment provided to patients Reg 17 The provider had not ensured they were delivering care and treatment in line with nationally recognised best practice, with clear leadership and oversight, including clear clinical leadership and oversight of the risks and all aspects of care and treatment delivery. Regulation 17 (2) (b)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had not ensured the staff had the skills to understand, treatment and care for patients in their care in compliance with 1.14 of the MHA Code of Practice. Regulation 11 (4)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	S31 Urgent variation of a condition Urgent action was taken because patients would or may be exposed to the risk of harm. The conditions placed require the provider not to admit or readmit any patients to Lavender, Aspen, Mulberry wards and Aspen Annex without prior agreement from CQC. In addition, the conditions require the provider to confirm in writing the actions they will take immediately and in the longer term to ensure medicines are managed safely, that there are robust systems of governance in place to ensure clear oversight of the care being delivered, ongoing monitoring and that improvements will be made in a timely manner.