The WoodHouse Independent Hospital

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?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
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.

Summary of findings

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

Overall summary

We rated Woodhouse hospital as requires improvement because:

- Staff did not regularly check medical emergency equipment for Lockwood and Highcroft to ensure it was in good working order when needed. Moneystone did not have automated external defibrillators and oxygen.
- Staff in Moneystone and Whiston did not practice good infection control procedures and food hygiene to protect patients and staff against the risks of infection.
- The wards were not fitted with nurse call systems in bedrooms and bathrooms for patients to alert staff to any emergency.
- Staffing levels fell below the required levels particularly at weekends and nights. There was a high rate of staff turnover and high use of agency. Activities and community leave were cancelled because there were not enough staff on duty.
- On call doctor covered a large geographical area including all the Lighthouse hospitals. This meant that the doctor would not always be able to get on site on time to support staff during an emergency when needed.
- There was no evidence that the safeguarding team were alerted to the patients in long-term segregation. Patients in long-term segregation did not have independent reviews taking place.
- Although staff had received training in autism, they demonstrated a limited understanding of caring for patients with autism. Staff did not recognise the need for a consistent structured routine to follow on a daily basis with individual patients.
- Staff had not received training on the revised Mental Health Act Code of Practice.
- Staff in wards for people with autism demonstrated a poor understanding of the Mental Capacity Act and found it difficult to demonstrate how the five statutory principles applied to practice.
- All staff should be receiving supervision in line with the provider's policy and good practice. The minimum standard for management supervision was one hour once every three months. 25% of permanent staff had not received supervision in the three months prior to our inspection on 21st October. There was system to monitor the additional requirement for clinical staff to receive clinical supervision.
- Staff did not always give patients copies of their care plans and record their views in care plans. Staff did not record patients' advance decisions. These are decisions made by patients about their wishes for future care.
- The hospital did not have an examination couch to carry out physical examination of patients. Moneystone and Highcroft wards did not have sensory rooms.
- The units did not offer enough meaningful and purposeful activities that promoted independent living skills. The activities appeared to focus more on leisure. Patients, relatives and staff told us that activities were limited on weekends and evenings.
- Relevant information for patients on subjects such as advocacy services, their rights and complaints was not available in easy-read versions.
- Staff from wards for people with autism did not demonstrate a good understanding of their team objectives and reported receiving mixed messages from senior management about the aims and objectives of the service.
- Staff morale was low particularly on the wards for people with autism where staff felt that senior management did not listen to their concerns. Staff told us that opportunities for clinical and professional development courses were limited.
- The governance processes to manage quality and safety did not effectively monitor and address these areas.
- The occupational therapy assistants felt they were working without clear clinical leadership and support in the absence of a qualified occupational therapist.

However:

Summary of findings

- The wards were clean and staff had carried out environmental risk assessments to identify potential ligature risks that might put patients at risk. They had put mitigating plans in place to manage them safely.
- All units carried out comprehensive assessments of need on admission. These included detailed risk assessments and risk management plans that were updated regularly after every incident. These care plans followed a positive behaviour support approach.
- Staff were trained in safeguarding and demonstrated a good understanding of how to identify and report abuse. Staff knew how to recognise and report incidents through the reporting system. Learning from incidents was shared with staff.
- In the clinical records we checked, we saw details of regular physical health checks.
- Patients could access psychological therapies as part of their treatment. For example, anxiety management and the adapted sex offender's treatment programme recommended by the National Institute for Health and Care Excellence.
- Staff treated patients with respect and dignity. They were polite, kind and willing to help. Patients and families were happy with the support they received from the staff and felt that they got the help they needed.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished. Patients and their families told us that they could access advocacy services when needed.
- Families and carers told us that they could raise any concerns and complaints freely.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Requires improvement 	Staff did not regularly check medical emergency equipment to ensure it was safe to use when needed. The wards were not fitted with nurse call systems to call for staff help in an emergency. Staff had not received training on the revised Mental Health Act Code of Practice. The governance processes were not effective enough to monitor and address quality and safety of the service.
Wards for people with learning disabilities or autism	Requires improvement 	Emergency equipment such as automated external defibrillators and oxygen were not readily available in the wards. Staff did not practice good infection control procedures and food hygiene to protect patients and staff against the risks of infection. Activities and community leave were cancelled because there were not enough staff on duty. Staff demonstrated a poor understanding of the Mental Capacity Act. Staff demonstrated a limited understanding of caring for patients with autism.

Summary of findings

Contents

Requires improvement

The Woodhouse Independent Hospital

Services we looked at:
Forensic inpatient/secure wards; Wards for people with learning disabilities or autism

Summary of this inspection

Background to The WoodHouse Independent Hospital

The Woodhouse is an independent mental health hospital, registered for the assessment and treatment of people detained under the Mental Health Act 1983. Patients admitted usually have a learning disability diagnosis and may have a history of offending behaviour.

The registered provider for the Woodhouse Hospital is Oakview Acorn Care Limited, which is part of the Lighthouse Group.

The provider had a nominated individual and a registered manager who was also the accountable officer for controlled drugs.

Regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983; Treatment of disease, disorder or injury.

The services on site are organised into three functional groups: a low secure ward, locked rehabilitation services and autism specific services.

Hawksmoor is an eight-bedded low secure ward for those requiring an environment of physical security because of the risk they present. Individuals may then step down into the locked rehabilitation services.

The locked rehabilitation service for learning disabilities comprises of Lockwood ward, 10 beds that focus on rehabilitation and preparation for discharge. Both Farm and Woodhouse Cottages are three-bedded units where independent living skills are developed.

The autism specific service includes the Moneystone unit, which provides eight beds for people with autism who present with significantly challenging behaviour, and the Whiston unit, six beds for people with autism. Highcroft is a four-bedded house where patients from Moneystone and Whiston may move to facilitate the development of daily living skills. The Kingsley unit was closed for refurbishment.

The hospital currently provides male-only accommodation.

The Woodhouse hospital has been registered with the CQC since 20 March 2011. There have been three previous inspections, the latest of which was carried out in May 2013. The service was found to be non-compliant with two standards relating to record keeping, assessing, and monitoring the quality of service provision.

Our inspection team

Team leader: Raphael Chichera

The team that inspected the service comprised four CQC inspectors, a Mental Health Act reviewer, an inspection manager and a range of specialists: one psychologist, one expert by experience and one learning disability specialist nurse.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- 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 stakeholders and families at two focus groups.

During the inspection visit, the inspection team:

- visited all wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- carried out observations of care using the short observational framework for inspection (SOFI) in Moneystone and Whiston;
- spoke with 12 patients who were using the service;
- spoke to seven family members;
- spoke with the registered manager and managers for each of the wards;
- spoke with 26 other staff members; including doctors, nurses, occupational therapy assistants, psychologist and education worker;
- received feedback about the service from two commissioners;
- spoke with an independent advocate;
- our expert by experience observed a hospital community meeting attended by seven patients and ten staff;
- attended and observed care programme approach (CPA) meetings for three patients;
- looked at 27 care and treatment records of patients;
- carried out a specific check of the medication management on all wards and units;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- our nurse specialist advisor and one of our inspectors attended a training session for staff.

What people who use the service say

Patients told us staff treated them with respect and dignity. They said staff were polite, kind and willing to help.

Patients and relatives told us there were no activities taking place during weekends and evenings.

Patients and relatives told us they were often not able to go out on Section 17 leave as planned because of a lack of staff.

Patients told us they discussed their care and treatment with staff but did not receive copies of their care plans.

Patients told us they attended their clinical review meetings and were encouraged to involve their relatives if they wished to. Relatives and families told us they were involved in care discussions and their views taken into account.

Patients told us they received information about the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Staff did not regularly check medical emergency equipment for Lockwood and Highcroft to ensure it was in good working order when needed. Some of the equipment was out of date and the sterile packaging for airways was absent. Highcroft, Whiston and Moneystone did not have automated external defibrillators and oxygen.
- Staff in Moneystone and Whiston did not practice good infection control procedures and food hygiene to protect patients and staff against the risks of infection. Fridge temperatures in Whiston and Moneystone were not consistently recorded.
- The wards were not fitted with nurse call systems in bedrooms and bathrooms for patients to alert staff to any emergency.
- Staffing numbers fell below the required levels particularly at weekends and nights. There was a high rate of staff turnover and consequently high use of agency and bank nurses to cover shifts. Activities and community leave were cancelled because there were not enough staff on duty.
- An on-call doctor covered a large geographical area including all the Lighthouse hospitals. This meant that the doctor would not always be able to get on site on time to support staff during an emergency when needed.
- Staff carrying out close observations had limited interactions with patients.
- Long-term segregation for two patients had not been reported to the local authority safeguarding team. Patients in long-term segregation did not have independent reviews taking place.

However:

- Staff carried out environmental risk assessments in areas such as health and safety, access to garden areas and kitchen, ligature risks and infection control and prevention.
- Each patient had a detailed risk assessment and risk management plan, which identified how staff were to support them. These care plans followed the positive behaviour support approach.
- Staff demonstrated a good understanding of how to identify and report any abuse.
- Medicines were appropriately stored and the temperatures regularly monitored.

Summary of this inspection

- Staff were able to explain how learning from incidents was shared within the team. Learning from incidents was discussed in staff meetings, reflective practice sessions and handovers.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Although staff had received training in autism, they demonstrated a limited understanding of caring for patients with autism. Staff did not recognise the need for a consistent structured routine to follow on a daily basis with individual patients.
- Staff had not received training on the revised Mental Health Act Code of Practice.
- Staff in the wards for people with autism demonstrated a poor understanding of the Mental Capacity Act and found it difficult to explain how the five statutory principles could be applied in practice.
- The arrangements in place were not robust and effective enough to monitor adherence to the Mental Health Act and Mental Capacity Act.
- All staff should be receiving supervision in line with the provider's policy at a minimum of one hour every three months .In the three months prior to our inspection on the 21st October 2015 the hospital manager reported that 24.8% had not met that standard. In addition, clinical staff are required to have clinical supervision, which is a mandatory requirement for qualified nurses, but no minimum frequency is outlined. A supervision report supplied by hospital management did not differentiate between these two types of supervision.

However:

- We looked at 27 records across the units and all contained comprehensive assessments completed when patients were admitted. Staff reviewed and updated these regularly to reflect discussions held within the clinical review meetings.
- Staff carried out physical health checks and continued to monitor physical health. Staff referred patients to specialist services when physical health concerns were identified and care plans were implemented to ensure those needs were met.
- The wards had records that were organised, stored securely and accessible to team members when needed.

Summary of this inspection

- Patients could access psychological therapies as part of their treatment. These included, for example, anxiety management and the adapted sex offender's treatment programme recommended by the National Institute for Health and Care Excellence.
- Staff carried out a wide range of regular clinical audits to monitor the effectiveness of the service provided. These included, for example, medicines management, record keeping and risk assessments.
- Staff received appraisals and had access to regular team meetings every month.
- There were regular and effective clinical review meetings that involved the relevant members of the multi-disciplinary team.

Are services caring?

Good 

We rated caring as good because:

- We observed positive interactions between staff and patients.
- Staff treated patients with respect and dignity and they were polite, kind and willing to help.
- Patients and families were happy about the support they received from the staff and felt they got the help they needed.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends, if they wished. Staff used different methods to communicate with patients through individuals' preferred methods of communication.
- Patients and their families told us that they were able to access advocacy services when needed.
- Staff gathered the views of relatives and families through questionnaires and family and carers' forums. The results informed positive changes within the hospital.

However:

- Staff did not always give patients copies of their care plans or record their views in care plans.
- Staff did not record patients' advance decisions. These are decisions made by patients about treatment choices in the future.
- Staff from the wards for people with autism struggled to explain how they meet the needs of patients with more complex needs.

Are services responsive?

Requires improvement 

We rated responsive to people's needs as good because:

Summary of this inspection

- The hospital did not have facilities to carry out the physical examination of patients on site. Hawksmoor ward occasionally used the entrance room to the ward for visitors. This meant limited privacy for patients and their visitors to meet. Highcroft did not have a quiet room where patients could sit quietly.
- Moneystone and Highcroft clinical environments lacked access to sensory activities and equipment. There were no photographs or symbols displayed to help orientate patients to the environment. Staff on duty lists and activities timetables were not presented in a visual form to support patients' understanding.
- The units did not have enough meaningful and purposeful activities that promoted independent living skills. The activities appeared to focus more on leisure. Patients, relatives and staff told us that activities were very limited on weekends and evenings.
- Relevant information for patients on subjects such as advocacy services, their rights and complaints was not available in easy-read versions.

However:

- Patients were only moved to other units for clinical reasons. All discharges and transfers were discussed in multi-disciplinary team meetings and were managed in a planned or co-ordinated way.
- Patients had access to hot drinks and snacks anytime of the day. Patients in the cottages had free access to the kitchen where they could make their own drinks.
- Patients were able to personalise their own bedrooms. Patients had a wide range of personal possessions on display.
- Interpreting services were available when needed to meet the needs of people who did not speak English well enough to communicate when receiving care and treatment. The provider obtained these services from external services.
- Staff offered patients a choice of food that met their dietary and religious needs and preferences.
- Information on how to make a complaint was displayed in the units. Patients could raise concerns with staff anytime. Staff were aware of the formal complaints process and described how they handled complaints.

Are services well-led?

We rated well-led as requires improvement because:

Requires improvement

Summary of this inspection

- Staff from wards for people with autism did not demonstrate a good understanding of their team objectives and reported receiving mixed messages from senior management about the aims and objectives of the service.
- Staff morale was low particularly in wards for people with autism where staff felt that senior management did not listen to their concerns. Staff reported low staffing levels, a fear of taking sickness absence, and rates of low pay. They said they were unable to take breaks, and did not have access to a staff toilet within the clinical areas during working hours. Staff had to wait for other staff to attend before proceeding to a toilet in the main office block.
- The governance processes to manage quality and safety did not effectively monitor and address areas such as emergency equipment, staffing levels, infection control and food hygiene procedures, long-term segregation and the evaluation of autism training.
- Staff told us that opportunities for clinical and professional development courses were limited.
- The occupational therapy assistants felt that they were working without clear clinical leadership and support in the absence of a qualified occupational therapist.

However:

- Staff knew who the most senior managers in the organisation were. These managers visited the unit.
- Staff told us that they knew how to use the whistle blowing process and felt free to raise any concerns
- Staff told us that their line managers supported them.
- Staff gave feedback on services and input into service development through the annual staff surveys and regular staff meetings.
- The unit used key performance indicators and other measures to gauge the performance of the team. Where performance did not meet the expected standard, action plans were put in place.
- Staff were open and transparent when things went wrong. Staff discussed incidents with patients, their families and care managers.
- Staff told us the hospital managers kept them informed about developments through emails and the intranet.

Detailed findings from this inspection

Mental Health Act responsibilities

Training records indicated that 85% staff had received training in the Mental Health Act (MHA) and the Code of Practice. However, staff told us that they had not received any training on the revised MHA Code of Practice.

The documentation we reviewed in detained patients' files was up to date, stored appropriately and compliant with the Mental Health Act and the Code of Practice. However, we were unable to locate the Approved Mental Health Professional (AMHP) reports in any of the files we looked at.

Consent to treatment and capacity forms were completed and attached to the medication charts of detained patients. In Hawksmoor, we could not find the responsible clinician's assessment of one patient's capacity to consent in the most recent authorisation of treatment. The hospital used a form called "assessment of capacity to give valid consent" for treatment decisions. This form did not correctly set out the requirements of the Mental Capacity Act.

Information on the rights of patients who were detained was displayed and independent mental health advocacy services were readily available to support patients. Staff were aware of how to access and support patients to engage with the independent mental health advocacy when needed.

The explanation of rights was routinely conducted and audited regularly. Easy read leaflets were made available to patients. The patient's level of understanding was recorded. Forms were signed by the staff and patients to show that they had understood their rights in respect of the Mental Health Act. Patients we spoke with confirmed this.

Staff knew how to contact the Mental Health Act administrator who was based at the hospital for advice when needed. There was no evidence that the provider carried out Mental Health Act audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that 84% of staff had received training in the Mental Capacity Act. However, staff in wards for people with autism demonstrated a poor understanding of Mental Capacity Act and found it difficult to demonstrate how the five statutory principles could be applied in practice.

Patients' capacity to consent was assessed and but not recorded in detail. These assessments were made on a decision–specific basis about significant decisions. There was lack of detailed information on how capacity to consent or refuse treatment had been sought. We looked at four mental capacity assessments on financial competence in Whiston carried out by the nurses. They lacked information on how decisions were reached to suggest that patients lacked capacity.

Patients were supported to make decisions where appropriate. When patients lacked capacity, decisions were made in their best interests, recognising the importance of their wishes, feelings, culture and history. We found a very good example of a best interests meeting that involved the ambulance service and the acute NHS hospital to secure medical treatment for a patient who lacked capacity. However, one patient in Whiston who was subject to DoLS did not have a best interest's decision in place to support ongoing treatment with psychotropic medication.

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

Staff knew the lead person to contact about Mental Capacity Act to get advice.

Deprivation of Liberty Safeguards applications were made when required. Two patients in Whiston were subject to Deprivation of Liberty Safeguards.

The arrangements in place to monitor adherence to the Mental Capacity Act were not robust and effective.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- The layout of Hawksmoor ward enabled staff to observe most parts of the communal areas of the ward. The ward had mirrors on corridors where views were restricted. Lockwood had similar features, and the two cottages were set up as homely living spaces.
- All the wards and independent living cottages were male only environments. The rooms on Hawksmoor and Lockwood had en-suite toilet and showers apart from one that had a bath. The cottages had shared male-only bathroom and toilet facilities.
- Staff had carried out assessments of potential ligature risks such as window latches, door handles and taps on both wards. The ligature risk assessments in Hawksmoor had specific actions in place to mitigate risks and staff were aware of the potential ligature points. On Lockwood ward, a ligature risk assessment had last been carried out in July 2014. The organisation's policy stated that annual reviews should be carried out. Such a delayed review could lead to potential risk to patients remaining unaddressed. All staff had received ligature training as part of their induction.
- The wards were well maintained and the corridors were kept clear and free from clutter. The wards were clean and patients told us that standards of cleanliness were usually good. Kitchen and clinical area records of cleaning were up to date. Staff conducted regular audits of infection control and prevention. Staff practiced good hand hygiene to protect patients and staff from the risks of infection.
- Hawksmoor and Lockwood wards had emergency equipment that included automated external defibrillators and oxygen. Staff in Hawksmoor carried out regular checks to ensure the equipment was fit for purpose and would be effective in an emergency. Lockwood ward shared the emergency equipment with the two cottages. At the time of inspection, the emergency bag could not be found on Lockwood. It was later found on another ward and returned to Lockwood ward. The equipment in the emergency bag was last checked on 18 June 2014. Some of the equipment had expired and the sterile packaging from airways removed. This meant that patients could not be assured that the equipment would be complete and effective in case of emergency.
- The wards had personal safety alarms available to ensure safety of staff, patients and visitors. However, the wards were not fitted with nurse call systems in bedrooms and bathrooms for patients to alert staff to any emergency.
- Portable appliance tests were carried out regularly and consistently for all equipment used. The unit's policy showed that the tests should be annual.
- Staff carried out environmental risk assessments in a variety of areas that covered health and safety. The delegated safety nurse reviewed environmental safety daily. This involved visual inspection of the internal environment, key checks and managing access to the garden. Each ward entrance displayed a detailed floor plan of the area and individualised evacuation plans for each patient in event of a fire.

Requires improvement

Forensic inpatient/secure wards

Safe staffing

- Hawksmoor had seven qualified nurses and 24 nursing assistants. There were no vacancies. This ward was staffed by two qualified nurses and five nursing assistants during the day and one nurse and four nursing assistants at night. Lockwood had nine qualified nurses and 31 nursing assistants. There were three vacancies for nursing assistants and none for nurses. This ward was staffed by two qualified nurses and five nursing assistants during the day and one qualified nurse and three nursing assistants at night.
- The sickness rate in the 12 month period to our inspection in October was 11% for Lockwood and 7% for Hawksmoor.
- Staff turnover for Lockwood was 22% and Hawksmoor was 6% in the twelve full months until our inspection in October. Combined annual turnover for qualified and support staff as at 30 September 2015 across the hospital was 38.5%
- There were 12 shifts filled by bank and agency staff in the last three months. The manager told us that most of the shifts covered by agency staff were for patients on high levels of observations.
- There were no shifts that had not been filled by bank or agency nurses, as result of staff sickness or absence in the last three months.
- The hospital manager had carried out regular reviews of staffing levels. We reviewed the staff rotas for the previous eight weeks prior to our inspection and saw that staffing levels were in line with the levels and skill mix determined by the provider as safe. The only exception occurred in response to late notice sickness absence where replacement staff could not be found in time.
- Managers told us that they were able to obtain additional staff when the needs of patients changed and more staff were required to ensure their safety. We observed that the wards ensured at least one qualified member of staff was working in the area of the wards where patients had unrestricted access. Staff in Lockwood told us that staffing levels in their ward had been reduced because of one patient being nursed out of the ward area during the day. We saw that one patient was nursed with two staff in one of the empty wards during the day. The manager told us that the patient was awaiting another placement after it was agreed that it was not suitable to keep the patient on that ward due to risks posed to other patients.
- Agency staff, who had not worked on a ward before, were given an induction to the ward. This included orientation to the layout of the ward. They were provided with written guidance on the local health, safety and security procedures for the ward. A folder was available in the staff office that contained all current behavioural support plans and current risks highlighted to new staff.
- Patients told us that sometimes there was not enough staff to escort patients on section 17 leave. Staff also told us that section 17 leave for patients was occasionally cancelled due to staff shortages. Staff told us that they made sure health appointments were never cancelled. Carers supported this assurance.
- The units had enough staff available to safely carry out physical interventions.
- Staff told us they could access medical input during the day. There were two consultants available on site during weekdays. At night and weekends, staff could call the out of hours doctor. All doctors within the Lighthouse hospitals cover the on-call doctor rota. The on-call doctor covered a large geographical area as far as 100 miles. However, staff told us that on all occasions they had only required verbal advice. With no medical staff on site overnight and at weekends, the hospital staff made use of the local emergency services to support them in the management of any medical emergency. Staff reported that in the management of a psychiatric emergency they could rely on telephone support of the on-call doctor. The MHA Code of Practice stated that whenever restrictive interventions were being used, provider's policies should make provision for the timely attendance of a doctor in response to staff requests concerning a psychiatric emergency whether in relation to medication or restraint.
- Records showed that the average rate for completed staff mandatory training was 84% on Hawksmoor and 85% on Lockwood and the cottages.

Assessing and managing risk to patients and staff

- Staff conducted individual risk assessments for all patients on admission. We looked at 16 records and saw

that, where risks were identified, measures were clearly identified on how staff could manage the risk. Individual risk assessments that we reviewed took account of patients' previous history, as well as their current mental state. In addition Historical Clinical Risk – 20 (HCR-20) and Sexual Violence Risk – 20 (SVR-20) were used as risk assessment tools.

- Staff regularly reviewed risk assessments and updated them after incidents. Staff completed antecedents, behaviour and consequences (ABC) forms after incidents and reviewed the information to support the development of positive behaviour support plans.
- Each patient had a person centred physical intervention management plan. These included triggers, early warning signs and de-escalation techniques to follow first and then staff should offer any medicines prescribed to the patient to be used as required. As a last resort, restraint techniques would be used. The plans included the physical health risks of the patient and in what circumstances required medicines would be given.
- Staff only used restraint after de-escalation had failed. The staff involved and methods of de-escalation used prior to restraint were recorded to indicate that it was only used after all other methods had been unsuccessful. Staff were trained in physical intervention and were aware of the techniques required. Staff completed an incident report following each incident.
- The wards did not use seclusion or long-term segregation.
- Hawksmoor had 10 and Lockwood had 12 episodes of restraint in the last six months. None were recorded as being in the prone position or involved the use of rapid tranquilisation.
- There was information to let informal patients know that they could leave the unit if they wanted to.
- The lounge in Hawksmoor was locked for patients between 10am and 4pm. Staff told us that was done to encourage patients to engage in activities. This was discussed with the hospital manager who reassured us that this would be stopped straightaway.
- The hospital had policies and procedures for use of observations to manage risk to patients and staff. Observations were clearly documented in patients' records. However, we saw that staff carrying out close observations had limited interactions with patients.
- Training records showed that 85% of staff received safeguarding training. Staff demonstrated an understanding of how to identify and report any abuse. There was information about awareness and how to report safeguarding concerns displayed around the units. Staff knew the designated lead for safeguarding who was available to provide support and guidance.
- Safeguarding issues were shared with the staff team through staff meetings, handover and emails. Information on safeguarding was readily available to inform patients and staff on how to report abuse. Patients and their relatives told us that they felt safe on the units.
- There were appropriate arrangements for the management of medicines. We found good links between Woodhouse and the pharmacy. We reviewed 16 medicine administration records across the units and the recording of administration was complete and correctly recorded as prescribed. The nurses checked the medicines stock levels each week to ensure that the correct doses were administered and adequate supplies in stock. Fridge and room temperatures were consistently recorded and maintained within the recommended range. Two nurses at each shift handover routinely checked controlled drugs.
- All visits from children were risk assessed and a separate visiting room in the main office area was made available.

Track record on safety

- On Hawksmoor ward there had been one serious incident in July 2015. This was as a result of a serious assault by one patient to another. The clinical team reviewed the incident and developed an action plan to address the key issues arising from the investigation. The risk assessment and management plan was updated immediately to reflect changes. They recommended changes to ensure that lessons learnt resulted in changes in practice.
- The root cause analysis identified that the other patient waited to attack when there were no staff around and found that when he was not occupied with activities, his risky behaviours increased. Staff attended a reflective practice session to learn and discuss how best to

manage that patient. Increased observations were carried out and staff were always aware of that patient's whereabouts and encouraged them to engage in activities at all times.
- We saw that recommendations made following the root cause analysis had been acted upon. The learning from this incident was shared with all staff in handover, team meetings and reflective practice group.

Reporting incidents and learning from when things go wrong

- There was an effective way of recording incidents, near misses and never events. Staff reported incidents via an electronic incident reporting form. They knew how to recognise and report incidents through the reporting system.
- Staff were open and transparent and explained the outcomes of incidents to patients, their families and commissioners. Any discussions with patients, families and commissioners about incidents were recorded on the incident form. Patients told us that they discussed any changes with staff after an incident.
- There was a clear structure used to review all reported clinical incidents weekly. Incidents sampled during our visit showed that thorough investigations took place, with clear recommendations and action plans for staff and sharing within the team.
- Staff could explain how learning from incidents was shared within the team. Learning from incidents was discussed in staff meetings, reflective practice sessions and handovers.
- From incident report, forms examined and staff reports there was consistent evidence that feedback and debriefings were regular occurrences following incidents.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at 16 records across the units and all contained a comprehensive assessment that staff completed when patients were admitted. These covered all aspects of care as part of a holistic assessment. Staff completed detailed personalised care plans that were regularly reviewed and updated to reflect discussions held within the clinical review meetings with patients. The care plans ranged from recovery and discharge, activities of daily living to managing behaviours that challenge.
- In the records we checked, we saw details of physical health checks and we saw that staff continued to monitor physical health. Staff referred patients to specialist services when physical health concerns were identified, and care plans were implemented to ensure that patients' needs were met.
- All patients had up to date and detailed person-centred care plans. Each patient had an up to date 'my shared pathway' document and could keep a copy if they wanted to. Staff had completed health action plans, nutritional assessments, communication passports, contingency plans, personalised, holistic and recovery orientated care plans.
- The wards managed care records appropriately using an electronic system. Records were organised, stored securely and team members could access patients' records when needed.

Best practice in treatment and care

- All medicines charts were reviewed and demonstrated that the National Institute for Health and Care Excellence guidance was followed when prescribing medication. Staff regularly monitored patients' physical health and the effects of antipsychotic medication.
- Patients could access psychological therapies as part of their treatment. The adapted sex offenders treatment programme (ASOTP), cognitive behavioural therapy, social skills and anxiety management were available as part of treatment programmes.
- The wards maintained close links with a local GP surgery to monitor patients' physical health needs and ensure physical health care plans were up to date. Annual health checks and regular physical health checks took place where needed. People had access to specialists such as dentists, a chiropodist, a podiatrist, the diabetic team, a dietician, and district nurses. All patients had up-to-date health action plans.
- Nurses and dieticians assessed patients for nutrition and hydration needs. Staff completed fluid and food charts and conducted weight checks each week.

- Health of the Nation Outcome Scales for learning disabilities (HoNOS-LD) was used as clinical outcome measures. In addition, 'my shared pathway' was used to gauge progress with patients from their perspective.
- Staff monitored progress regularly in care records and recorded data on progress towards agreed goals in each patient's notes.
- Staff carried out a wide range of regular clinical audits to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis such as physical intervention, records keeping, nutrition and hydration, care programme approach, medicines, care plans and risk assessments. It was used to identify and address changes needed to improve outcomes for patients.

Skilled staff to deliver care

- The team consisted of a doctor, nurses, nursing assistants, a speech and language therapist, activity coordinators, a psychologist and the occupational therapy assistants. The team had range of learning disabilities disciplines and workers to ensure that patients received the care they needed. There was no occupational therapist in post at the time of inspection but one had already been appointed to start in December 2015. Speech and language therapy was provided on a part-time basis for two sessions a week. The pharmacist was not part of the multidisciplinary team and did not attend the multidisciplinary team meetings. However, was involved in reviewing patients' prescription charts and checking for errors, dosages and contraindications. The pharmacy service provided advice service which could be accessed by doctors and nurses. Patients and relatives told us that they were able to see a wide range of professionals depending on their needs.
- Staff told us they had undertaken training relevant to their roles. Staff were trained in positive behaviour support, epilepsy, diabetes, dysphagia, nutrition and diet, dysphagia and autism.
- New staff had a period of induction, which involved shadowing experienced staff before they were included in staff numbers.
- Staff received appraisals and had access to regular team meetings every month. The average rate of staff that had an appraisal in the last 12 months was 88%.
- In the three months prior to our inspection on the 21st October 2015, the hospital manager reported that 25% had not received supervision in line with the provider's policy. The provider's policy stated that each staff member should receive supervision at a minimum of one hour every three months.

Multi-disciplinary and inter-agency team work

- We looked at 16 records of multi-disciplinary team meetings and found that the wards had regular involvement from other health professionals such as a speech and language therapist, occupational therapy assistants, a psychologist and external social workers. The unit had regular and effective clinical review meetings that involved the relevant members of the multi-disciplinary team working with the patient.
- The units had effective handovers. We looked at handover information and found that they included feedback from review meetings, any changes in care plans, patients' physical health, mental state, risks, observations and incidents.
- Woodhouse had good working relationships with external organisations. They worked together to review the risk assessments and crisis plans within the care programme approach process and facilitated safe discharge. They had effective partnership working with GPs, hospitals, local community facilities, local authorities, and health commissioners.
- Staff told us that they had developed good working relationships with the local GP and district nurses. The GP visited patients on the unit who were unable to go to the surgery. Staff told us that information sharing and access was easy between internal and external professionals.
- We saw that families, patients and external professionals attended patients' care programme approach meetings. Patients and their families told us that other professionals who were involved in their care and treatment attended their meetings.

Adherence to the MHA and the MHA Code of Practice

- Training records indicated that 85 % staff had received in Mental Health Act (MHA) and the Code of Practice. Staff told us that they had not received any training in respect of the revised MHA Code of Practice. We could not find clinical policies had been updated to reflect the revised MHA Code of Practice.
- All patients were detained under the 'Act'.
- The documentation we reviewed in detained patients' files was up to date, stored appropriately and compliant

with the Mental Health Act and the Code of Practice. However, we were unable to locate the Approved Mental Health Professional (AMHP) social circumstances reports in any of the files we looked at.

- Consent to treatment and capacity forms were completed and attached to the medication charts of detained patients. In Hawksmoor, we could not find the responsible clinician's assessment of one patient's capacity to consent at the most recent authorisation of treatment. The hospital used a form called "assessment of capacity to give valid consent" for treatment decisions. This form did not correctly set out the requirements of the Mental Capacity Act.
- Information on the rights of patients who were detained was displayed and independent mental health advocacy services were readily available to support patients. Staff were aware of how to access and support patients to engage with the independent mental health advocacy.
- The explanation of rights was routinely conducted and audited regularly. Easy-read leaflets were made available to patients. Staff recorded patients' level of understanding. Staff and patients signed the forms to show that they had understood their rights in respect of the Mental Health Act. Patients we spoke with confirmed this.
- Staff knew how to contact the Mental Health Act administrator who was based at the hospital for advice when needed. There was no evidence that the provider carried out Mental Health Act audits.

Good practice in applying the Mental Capacity Act

- Training records showed that 85% staff had received training in the Mental Capacity Act.
- However, staff demonstrated a poor understanding of Mental Capacity Act and found it difficult to explain how the five statutory principles could be applied in practice.
- Staff assessed and recorded patients' capacity to consent. These were done on a decision–specific basis for significant decisions. There was detailed information on how capacity to consent or refuse treatment had been sought.
- Staff supported patients to make decisions where appropriate. When patients lacked the capacity, decisions were made in their best interest, recognising the importance of their wishes, feelings, culture and history.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- Staff knew the lead person to contact about Mental Capacity Act to get advice.
- Deprivation of Liberty Safeguards applications were made when required. None of the patients were subject to Deprivation of Liberty Safeguards.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We observed good quality interactions between staff and patients. Staff spoke to patients in a way that was respectful, clear and showed positive engagement and a desire to support patients.
- Patients and families were complimentary about the support they received from the staff and felt staff provided the help they needed. Our observations and discussions with patients and their families confirmed that they had been treated with respect and dignity. Staff were polite, kind and made them feel at home.
- Staff demonstrated a good understanding of the needs of patients and were able to demonstrate detailed knowledge of the patients and their preferences.

The involvement of people in the care they receive

- We observed two care programme approach (CPA) meetings in which service users were present. In a hospital wide survey 93% of patients reported regularly attending their multi-disciplinary team meetings and felt that they had been involved in decisions about their care and treatment. Staff gave patients copies of their care plans if they wished.
- Staff encouraged patients to involve their relatives and friends if they wished. Family members' views were taken into account and they were happy about the way they were involved in care discussions.
- Asist, a locally commissioned provider, provided advocacy service. We saw posters around the unit. Staff

supported patients to make contact with the service. Staff also referred patients. Patients told us they could access advocate services when needed. They told us advocates visited weekly.

- We witnessed a high level of patient and carer involvement in the running of the hospital. The hospital conducted regular monthly community meetings led by the hospital manager. We attended a community meeting attended by seven patients. We found that the discussions were relaxed and the patients were comfortable to raise issues. A patient chaired the meeting and issues discussed included patients' input into CPA meetings, smoking and how patients would like to be addressed by staff.
- The hospital completed an annual patient survey in June 2015. The hospital received a 20% response. Of the respondents, 53% reported involvement in writing their discharge care plans. All respondents participated in planning the food they ate weekly. In planning their activities programme, 53% of respondents reported they were actively involved.
- Families and carers told us that the manager invited them to open days and carers forums at the hospital. They were able to give feedback about how the hospital was run. They also received a newsletter to inform them about developments at the hospital.
- Staff did not record patients' advance decisions. These are decisions made by patients how they would like to be treated in the future. The manager told us that they were going to act on that to ensure that where appropriate this would be recorded.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The average bed occupancy was 85% over the six months until the end of September 2015.
- The provider knew where all patients admitted came from and worked closely with the care managers, commissioners and local authorities to ensure that all patients were helped towards their discharge. All discharges and transfers were discussed in the multi-disciplinary team meeting and were managed in a planned or co-ordinated way.
- The patients included out of area placements and all patients had received care and treatment reviews (CTR) within the last 12 months. The team discussed discharge plans at the first clinical review of each patient after admission. Staff told us that they invited social workers and case managers to CPA meetings and discharge planning meetings. The manager told us that they held meetings with NHS England and Clinical Commissioning Groups (CCGs). They said this ensured that they all worked towards the same goal to ensure that patients had the assessment and treatment they needed and discharge was planned on the individual needs of patients.
- All the files we looked at had discharge plans. Staff informed us that where a patient was ready for discharge the local authority will be involved and a gatekeeping assessment will be initiated. Patients were discharged within the step down units on the hospital site or to other locations. Staff informed us four patients were nearing discharge.
- Patients were able to clearly tell us what their discharge plans were and where they would be moving. One patient told us he would be visiting his next placement next week.
- The manager and staff told us that they had found that the CTR process was helpful in unblocking barriers to discharge. The CTR involved the patient, their relatives, advocates, all relevant professionals in the MDT and social services from the patient's admission.
- The hospital manager did not calculate an average length of stay as there was too low a turnover of patients through the service to make it a meaningful outcome measure. Each individual patient's stay was monitored through their annual care and treatment reviews. Staff told us that they tried to keep patients' length of stay to a minimum but as patients were at risk of offending this was based on individual risk. They told us that they constantly assess the risk with a view to move them on.
- Patients on leave could access their own beds on return from section 17 leave.
- The team only moved patients to another unit for clinical reasons. The service had a treatment clear

pathway. The hospital admitted patients to either Hawksmoor or Lockwood and were moved to the cottages if they had progressed after a period of assessment and treatment.

- If a patient required more intensive care and could no longer be safely managed on the unit, the care manager and commissioners would be contacted to find a suitable placement. We saw one patient where the provider was working with the commissioners to find a suitable placement after they had agreed to nurse the patient in an empty ward during the day.
- At the time of our inspection, there were two delayed discharges. The longest delayed discharge was four months. The manager was negotiating with the commissioners to find a suitable placement. The reason for the delays was that no suitable placements had been identified or they were waiting for beds in less restrictive placements.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital did not have the appropriate facilities to carry out a full physical examination of patients. The manager told us that they encouraged patients to access the GP practice. The hospital had a plan to develop an examination room by December 2015.
- Hawksmoor ward occasionally used the entrance room to the ward for visits. This room had limited privacy as patients and staff used the room to enter and exit the ward. Staff told us that patients could use a designated hospital visitors' room in the main office area that was private and away from the patient area. Patients had access to their mobile phones and could make phone calls in private. The telephone on Hawksmoor ward was in the entrance area to the ward and had limited privacy.
- Patients could access the garden area on the Hawksmoor and Lockwood wards with staff supervision. Patients in the cottages had free access to the garden areas and the inner courtyard of the hospital.
- Patients reported mixed views about the quality of food. Some patients were not happy with the portion sizes and others with the choice of menus, which had been affected by the introduction of healthy eating initiatives. The ward had consulted patients to sample items from the proposed winter menu and choose their favourites. We observed the feedback of the consultation in the community meeting we attended. The annual patient survey reported 80% approval of the menu. Patients also had many opportunities to shop and cook for themselves.
- Patients had access to hot drinks and snacks anytime of the day. Patients in the cottages had free access to the kitchen where they could make their own drinks. Staff supervised patients when accessing the kitchen in Hawksmoor and Lockwood. Staff told us that this was assessed on an individual basis and according to risk assessment.
- Patients were able to personalise their own bedrooms. Patients had a wide range of personal possessions on display. Patients in the cottages were proud to show us their rooms that had a variety of personal items that reflected their interests such as the football teams they supported.
- Each patient had an individual allocated locked storage area where personal valuables could be secured. Patients in the cottages and Lockwood had their own bedroom keys.
- There was a range of activities offered to patients in all wards. Each patient had an individual programme of activities. The hospital had an education centre that supported educational, vocational and recreational activities and programmes as the hospital was located away from many local facilities. Patients, relatives and staff told us that activities were very limited on weekends and evenings. Limited input from an occupational therapist resulted in lack of meaningful and purposeful activities that promoted patients' community living skills. We could not find individual occupational therapy assessments that were regularly reviewed to show that patients had been assessed to identify skills required for independent living.

Meeting the needs of all people who use the service

- The wards had assisted bathrooms for patients with mobility issues.
- The wards had information leaflets about the service provided. However, this information was not available in an easy read format.
- Interpreting services were available when needed to meet the needs of people requiring support to communicate when receiving care and treatment in a language other than English. These were obtained from external services.

Requires improvement

Forensic inpatient/secure wards

- Staff provided patients and their families with limited information leaflets, which were specific to the service provided. Relevant information for patients on subjects such as advocacy services, their rights and complaints was not available in easy-read versions.
- All wards offered and supported patients with the choice of food they wanted to meet their dietary requirements and to meet their religious and ethnic needs.
- All patients had 'my shared pathway' where details of the patient's needs were highlighted, such as likes and dislikes, activities, cultural, religious, ethnic and spiritual needs. All of these were discussed with the patient and family, where appropriate. Communication passports were in all of the files we reviewed.
- One patient in Hawksmoor unit had diagnosis of early onset dementia. A review was held to determine whether the unit was still appropriate to meet this patient's needs. Family were included in the best interest decision meeting. The patient's condition was currently stable and it was decided the patient was appropriately placed.
- There were contact details for representatives from different faiths. Staff supported patients to meet their spiritual needs. There was no dedicated multi-faith room on site. The manager told us that they supported patients to go out to church to meet these needs.

Listening to and learning from concerns and complaints

- Hawksmoor Ward received two complaints between August 2014 and July 2015 of which one was upheld. Lockwood received eight complaints of which seven were upheld and the cottages produced eight complaints of which seven were upheld. The majority of complaints were around delays or cancellations of formal meetings. The manager addressed this by ensuring that all meetings were planned by administration ahead of time and shared with all clinical staff to keep the dates clear.
- The wards displayed information on how to make a complaint. . Patients could raise concerns with staff anytime. Families and carers told us that they were able to raise any concerns and complaints freely. Some family members informed us that they were not aware of the formal complaints procedure. However, they said they could raise concerns directly with manager and felt listened to.
- Staff told us they tried to resolve patients' and families' concerns informally at the earliest opportunity. We observed that staff responded appropriately to concerns raised by relatives and carers of patients and received feedback. Staff were aware of the formal complaints process and knew how to support patients and their families when needed.
- Our discussion with staff and records observed showed that any learning from complaints was shared with the staff team through the handovers and staff meetings.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

- The organisation's vision and values for the service were evident and were on display in some wards. Staff on all wards demonstrated that they understood the vision and direction of the service. The organisation aimed to deliver the highest level of recovery focussed care in a planned and therapeutic approach for patients with forensic and mental health needs.
- In light of the Winterbourne review, the hospital managers had developed a new model of service delivery. The team identified and planned how patients with forensic and mental health needs would be transferred within the hospital taking into consideration relationships, risks and the stage achieved on their pathway. This would also be looking at review of placements by commissioners. The aim was to equip patients with skills in activities of daily living and prepare for moving on towards the community.
- Ward managers had regular contact with their service manager and hospital manager. Staff knew the senior organisation managers and told us that they sometimes visited the wards.

Good governance

- The wards had governance processes to manage quality and safety. The units used these methods to give information to senior management in the organisation to monitor their quality and safety. Staff received mandatory training and appraisals. Staff participated in clinical audits and reported incidents. Staff learnt from

incidents, complaints and patients feedback. However, the governance processes were not effective and robust enough to ensure that quality and safety of the service is always maintained. The inspection team identified areas where improvements were needed. The areas that were not monitored effectively were emergency equipment, meaningful and purposeful activities, advance decisions, staff supervision, staff morale, Mental Health Act training update and nurse call systems.

- The wards provided data on performance to the hospital manager consistently. All information provided was analysed to come up with themes and this was measured against set targets. Each ward's performance results were published every month. Where performance did not meet the expected standard, action plans were put in place. We saw action plans of improving performance in areas that had been identified from data on performance. The performance indicators were discussed weekly and monthly in the incident review meetings, the clinical governance and the health and safety meetings.
- The managers felt they were given the independence to manage the teams and had administrative staff to support the wards. They also said that, where they had concerns, they could raise them. If appropriate, the concerns could be placed on the hospital's risk register.

Leadership, morale and staff engagement

- There were no grievances being pursued, and there were no allegations of bullying or harassment.
- Staff told us that they were aware of the organisation's whistleblowing policy and that they felt free to raise concerns. However, staff told us that the felt the senior management did not listen to their concerns.
- Staff told us that opportunities for clinical and professional development courses were limited.
- Our observations and discussion with staff confirmed that the teams worked well together. Staff in Hawksmoor told us that morale within the ward was good, particularly compared to the service for people with autism. Staff in Lockwood told us that morale was low due to staffing levels because of one patient being nursed out of the ward area during the day. They told us their concern that at night one qualified nurse covered Lockwood ward and the two cottages. Staff spoke positively about their role and demonstrated their dedication to providing high quality patient care. They told us that staff supported each other within the team. Staff felt supported by their ward manager.
- Staff reported different experiences of management support. Some said that managers were accessible to staff, promoted an open culture, invited new ideas on how to improve the service and were willing to share ideas. Other staff told us that the managers were not very approachable and supportive. For example, their concerns over not being able to take breaks, access to a staff toilet during working hours, a fear of taking sickness absence and rates of pay, were not being addressed.
- The supervision arrangements of the occupational therapy assistants, in the absence of a qualified occupational therapist, were not clear. The occupational therapy assistants felt that they were working day to day without clear clinical leadership and support. They did not have access to any previous electronic patient records and no handover material was prepared for the new post holder.
- Staff were open and transparent when things went wrong. Incidents were discussed with patients, their families and care managers. Patients, families and care managers told us that they were informed and given feedback about things that had gone wrong.
- Staff told us the senior management team informed them about developments through emails and intranet and sought their opinion through the annual staff surveys.

Commitment to quality improvement and innovation

- The Woodhouse Hospital participated in a number of external quality reviews as part of their quality assurance arrangements. Hawksmoor ward participated in the Quality Network for Forensic Mental Health Services (QNFMHS) peer review in the last year. In its report published in April 2015, Hawksmoor was compliant with 75% of the standards addressed.
- Hawksmoor Ward LSU has been the subject of a peer review under the auspices of the Quality Network for Forensic Mental Health Services (QNFMHS) in the last year. In their report published in April 2015 Hawksmoor was compliant with 75% of the standards addressed. Environmental concerns were around the lack of a multi faith room, the dual use of the visiting room as an entry

to the ward and private room for communications and lines of sight along the corridors. Staff protocols around key management, level of security training and frequency of supervision identified as concerns.

- Positively the review highlighted good practice in positive staff engagement with patients, allowing open access to facilities and links to activities beyond the hospital. They observed positive working relationships between the staff team and praised the levels of staff retention on the ward.
- During our inspection, we reviewed a red amber green (RAG) rated action plan to address the unmet standards at the time of the QNFMHS visit.
- NHS England and the NHS Wales quality assurance teams had visited the wards and produced a report of their inspection in January 2015. Overall their findings were that 74/78 of their standards were being maintained.
- The wards did not have accreditation for inpatient learning disability services from the Royal College of Psychiatrists.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and Clean Environment

- The layout of all units enabled staff to observe most parts of the unit effectively. The units had cctv cameras in all communal areas.
- The units had anti-ligature windows and bedroom furniture. Some of the door handles were anti-ligature. There were potential ligature points on bedroom door handles, taps and showers in the bedroom en-suite bathrooms. These were identified in the ligature risk assessment. The hospital had a detailed risk management plan describing how to minimise this risk for each patient. The manager told us any risk of suicide was identified on admission assessment and that they would not admit any patients with a high risk of suicide.
- All units offered single sex accommodation for males with en-suite toilet and bathing facilities.
- The units had clinic rooms, which had only limited equipment available to conduct basic physical health observations. There was no emergency bag to carry out basic life support available in Highcroft and Moneystone. Across all three units, there was no emergency equipment such an automated external defibrillators and oxygen. Staff informed us that this equipment was available from Hawksmoor ward. The teams had not carried out any drills to test how long it would take to get the equipment in an emergency. There could be a significant delay in providing equipment to these units.
- On Highcroft, records showed that the emergency bag available was last checked on 15 April 2015. This meant that patients could not be assured that the equipment would be complete and effective in case of emergency. According to National Institute of Health and Care Excellence (NICE), this equipment should be checked weekly.
- The units were clean, with suitable furniture and were well maintained. However, in Moneystone, the walls were blank with no pictures or other decoration creating a dull atmosphere. Patients and relatives told us that the level of cleanliness was good.
- Staff carried out regular audits of infection control and prevention. However, staff did not practice good infection control procedures and food hygiene to protect patients and staff from the risks of infection. For example, in Whiston, staff had placed cooked breakfast food in a plastic container for patients to eat, but left it out at room temperature for patients to eat later. Food in the patients' fridge was not labelled as to when it was opened. Fridge temperatures in Whiston and Moneystone were not consistently recorded.
- Staff carried out environmental risk assessments in areas such as health and safety, access to therapy rooms, use of any equipment and infection control and prevention.
- Portable appliance tests was carried out regularly and consistently for all equipment used. The unit's policy showed that the tests should be carried out yearly.
- All staff had personal safety alarms that helped to ensure the safety of patients and that of staff. However, the units did not have nurse call systems to allow patients to call for help when needed.

Safe staffing

Requires improvement

Wards for people with learning disabilities or autism

- Moneystone was staffed by one qualified nurse and seven nursing assistants during the day and one nurse and three nursing assistants at night. Whiston was staffed by one qualified nurse and six nursing assistants during the day and one nurse and four nursing assistants at night. Highcroft was staffed by one qualified nurse and five nursing assistants during the day and five nursing assistants during the night. One of these nursing assistants could be shared with Whiston during the night to allow the attendance of the qualified nurse from there to Highcroft if required.
- The establishment for this service for people with autism as a whole was one clinical nurse manager, 10 staff nurses and 65 nursing assistants. There were three vacancies for qualified nurses and 21 for nursing assistants.
- During September 2015, the units used an average of 900 hours a week on bank and agency staff to fill shifts predominantly to cover for staff vacancies in this service.
- The manager had reviewed the numbers and grade of staff required for each unit by assessing individual patient needs. For example, the manager allocated more staff to the unit where patients required higher levels of observation. The teams had a system in place to report daily staffing levels to management for weekly review. The hospital manager was actively monitoring staff shortages and recruiting new staff to address the situation. The number of staff on the rota for the last three months was not always consistent. Staff reported and we saw from the staff rota that staffing numbers fell below the required levels particularly at weekends and nights. Families told us it was common at weekends that the units were short staffed, and relied on agency staff.
- There was high use of agency and bank nurses to cover sickness, special observations, annual leave and vacancies. The managers told us that the agency and bank staff used were familiar with the units and patients. The agency staff were given a detailed induction and were booked in advance to cover shifts.
- Activities and community leave were frequently cancelled because there were not enough staff on duty. We looked at the log of community leave and saw that patients could not access community leave on a daily basis. Staff told us that leave would be limited to local walks that required less staff than more purposeful therapeutic community activities that required more staff. Families told us patients were not able to go out regularly to community activities due to staff shortages.
- The units did not have enough staff available so that patients could have regular one-to-one time with their named nurse. Staff told us that they had to spend long periods on 1:1 observations beyond the two hours recommended in the units' policy. We saw on Whiston that the number of staff on duty could not support the required breaks from constant close patient observation, as per policy. Staff told us that it was not always possible to take rest breaks during a 12-hour shift and that they often finished late. There were enough staff to carry out physical interventions safely.
- Staff told us they could access medical input during the day. There were two consultants available on site during weekdays. At night and weekends, staff could call the out-of-hours doctor on call. The on-call doctor would cover a large geographical area including all the Lighthouse hospitals and would not always be able to get on site to support staff during an emergency. Telephone support was used and there was no evidence that medical personnel had been required in person during any emergency.
- Records showed that the average rate for completed staff mandatory training was 86%.

Assessing and managing risk to patients and staff

- Staff carried out risk assessments when patients were admitted. This took account of previous history, risk, social and health factors. Staff regularly reviewed and updated these. In addition Historical Clinical Risk – 20 (HCR-20) and Sexual Violence Risk – 20 (SVR-20) were used as risk assessment tools.
- Each patient had a detailed risk assessment and risk management plan, which identified how staff were to support them. The unit used strategies for managing patients' behaviours drawn from the positive behaviour support approach. Each patient had a person centred management plan. These included triggers, early warning signs and de-escalation techniques to follow first and then staff should offer any medicines prescribed to the patient to be used as required. They included primary, secondary and tertiary responses. The plans included the physical health risks of the patient and in what circumstances in which when required medicines would be given. We saw good

de-escalation skills demonstrated by staff when patient in Moneystone was agitated. Staff handled the situation very well before it could escalate into aggression. The patient was threatening staff but staff showed that they were aware of the patient's early warning signs and knew the distraction techniques for the individual.

- Staff only used restraint after de-escalation had failed. The staff involved and methods of de-escalation used prior to restraint were recorded to indicate that it was only used after all other methods had been unsuccessful. Staff were trained in physical intervention and were aware of the techniques required. Staff completed an incident report following each incident.
- There were 137 episodes of restraint on Moneystone, 55 on Whiston and 28 on Highcroft in the first six months of 2015. None were recorded as being in the prone position or involving the use of rapid tranquilisation.
- The units did not use seclusion. Long-term segregation was used for two patients, one in Whiston had used it for six months and one in Moneystone for four years. One in Whiston was being gradually re-integrated back onto the main ward and had a care plan around that. Both patients had clear and detailed care plans for long-term segregation. The multi-disciplinary team held comprehensive weekly reviews. The families had been involved in the decision and ongoing reviews. The families involved told us that they were involved and happy with the care provided. There was no evidence the safeguarding team had been notified in line with the Mental Health Act Code of Practice. We were told that a telephone referral had been made but staff had not recorded this. Patients in long-term segregation did not have independent reviews taking place. Hospital managers informed us that they had been trying to get independent reviewers but it had been difficult to do so. We saw correspondence that showed these attempts had been made.
- There was information to let informal patients know that they could leave the unit if they wanted to.
- The unit had policies and procedures for use of observations to manage risk to patients and staff. Observations were clearly documented in patients' records. However, we saw that staff carrying out close observations had limited interactions with patients.
- Training records showed that 85% of staff received safeguarding training. Staff demonstrated a fair understanding of how to identify and report any abuse. There was information about awareness and how to report safeguarding concerns displayed around the units. Staff knew the designated lead for safeguarding who was available to provide support and guidance.
- Safeguarding issues were shared with the staff team through staff meetings, handover and emails. Information on safeguarding was readily available to inform patients and staff on how to report abuse. Patients and their relatives told us that they felt safe on the units.
- The units did not use rapid tranquilisation. We looked at 11 prescription charts and there was no rapid tranquilisation prescribed.
- There were appropriate arrangements for the management of medicines. We found good links between Woodhouse and the pharmacy. The pharmacy service provided advice service which could be accessed by doctors and nurses. We reviewed 11 medicine administration records across the units and the recording of administration was complete and correctly recorded as prescribed. The nurses checked the medicines stock levels each week to ensure that the correct doses were administered and adequate supplies in stock. Fridge and room temperatures were consistently recorded and maintained within the recommended range. Two nurses at each shift handover routinely checked controlled drugs.
- All visits from children were risk assessed and a separate visiting room in the main office area was made available.

Reporting incidents and learning from when things go wrong

- There was an effective way of recording incidents, near misses and never events. Staff reported incidents via an electronic incident reporting form. They knew how to recognise and report incidents through the reporting system.
- Staff were open and transparent and explained the outcomes of incidents to patients, their families and commissioners. Any discussions with patients, families and commissioners about incidents were recorded on the incident form. Relatives told us that they discussed any changes with staff after an incident but felt that sometimes there was a delay in notifying them.

Requires improvement

Wards for people with learning disabilities or autism

- There was a clear structure used to review all reported incidents weekly. Incidents sampled during our visit showed that thorough investigations took place, with clear recommendations and action plans for staff and sharing within the team.
- Staff could explain how learning from incidents was shared within the team. Learning from incidents was discussed in staff meetings, reflective practice sessions and handovers.
- The managers offered staff debriefs and support after serious incidents.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at 11 records across the units and all contained a comprehensive assessment that had been completed when patients were admitted. These covered all aspects of care as part of a holistic assessment. Staff completed detailed individualised care plans that were regularly reviewed and updated to reflect discussions held within the clinical review meetings.
- In the records, we checked we saw details of regular physical health checks and we saw that that staff continued to monitor patients' physical health. Staff referred patients to specialist services when physical health concerns were identified and care plans were implemented to ensure that patients' needs were met.
- Patients had up to date and detailed person-centred plans. They had up to date health action plans, nutritional assessments, communication passports, contingency plans, personalised, holistic and recovery-orientated care plans. The units used 'My shared pathway' documents to record patient involvement in care planning and their feedback to multi-disciplinary team and one to one meetings about their recovery. This clearly demonstrated a person-centred care approach.
- The unit managed care records appropriately using 'care notes', an electronic system. Records were organised, stored securely and team members could access patients' records when needed. Risk assessment and behaviour support plans were also available as paper records for easy access by agency staff.

Best practice in treatment and care

- Fourteen medicines charts and care records sampled showed that the National Institute for Health and Care Excellence guidance was followed when prescribing medication. Patients were monitored and staff regularly recorded their responses to treatment, including changes in symptoms and behaviour.
- Patients could access psychological therapies and assessments as part of their treatment, for example, functional analysis of behaviour, anxiety management and therapeutic support programme recommended by the National Institute for Health and Care Excellence (NICE).
- The unit maintained close links with a local GP surgery to monitor the physical health needs of patients and ensure physical health care plans were kept up to date. Staff carried out annual health checks and regular physical health checks. Patients had access to specialists such as in primary and secondary physical health care. Relatives told us that patients were supported by their nurses to visit the GP and attend hospital appointments.
- Nurses assessed patients for nutritional and hydration needs. Speech and language therapists (SALT) carried out dysphagia assessments. Staff completed fluid and food charts and conducted weekly weight checks. .
- Health of the Nation Outcome Scales learning disabilities (HoNOS-LD) was used as clinical outcome measures. In addition, staff used 'my shared pathway' to gauge progress with patients from their perspective.
- Staff monitored progress regularly in care records and recorded data on progress towards agreed goals in each patient's notes.
- Staff carried out a wide range of regular clinical audits to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis such as physical intervention, record keeping, nutrition and hydration, care programme approach, medicines, care plans and risk assessments. The audits helped identify and address changes needed to improve outcomes for patients. Of the seven clinical audits scheduled in 2015, Whiston had completed six, Moneystone 3 and Highcroft only two.

Requires improvement

Wards for people with learning disabilities or autism

Skilled staff to deliver care

- The team consisted of a doctor, nurses, nursing assistants, a speech and language therapist, psychologists and the occupational therapist assistants. At the time of our inspection, there was no qualified occupational therapist in post. Speech and language therapy was very limited. It was provided on part-time basis for two sessions a week. We were told that a new recruit would be starting in December. The pharmacist was not part of the multidisciplinary team and did not attend the multidisciplinary team meetings. However, was involved in reviewing individual patients' prescription charts and checking for errors, and contraindications. Patients and relatives told us that they were able to see a wide range of professionals depending on their needs.
- The managers offered staff training that was specific to their roles such as autism, epilepsy, dysphagia, Makaton and positive behaviour support. However, staff demonstrated a limited understanding of caring for patients with autism. Staff did not recognise the need for a consistent structured routine to follow on a daily basis with individual patients. Staff did not realise the importance of adaptations to the physical environment for patients with hyperactive- and/or hypo-sensory sensitivities. For example, the potential impact of environmental light, noise and wall colours was not understood.
- The psychologist provided training and support in the development of positive behaviour support plans for individual patients. Unfortunately, the effectiveness of these plans were undermined by high use of agency and bank staff.
- One member of staff on Highcroft told us that they completed a two-day autism course delivered by "positive about autism". Staff told us that they would like more training around autism that would give them enough skills to care for people with autism.
- New staff had a period of induction before they were included in staff numbers. During that period, they received mandatory training.
- Staff received appraisals and had access to regular team meetings every month. The average rate of staff that had an appraisal in the last 12 months was 88%.
- In the three months prior to our inspection on 21 October 2015, the hospital manager reported that 25% had not received supervision in line with the provider's policy. The provider's policy stated that each staff member should receive supervision at a minimum of one hour every three months.

Multi-disciplinary and inter-agency team work

- We looked at 11 records of multi-disciplinary team meetings and directly observed two meetings. We found they included regular involvement of a range of health professionals such as doctors, nurses, psychologists and external social workers. The unit had regular and effective clinical review meetings that involved the relevant members of the multi-disciplinary team working with the patient.
- The units had effective handovers. We looked at handover information and found they included feedback from review meetings, any changes in care plans, patients' physical health, mental state, risks, observations and incidents.
- The autism service had good working relationships with external organisations. Community nurses and social workers worked in partnership with the unit to gather information about risks, clinical needs and discharge planning. They worked together to review the risk assessments and crisis plans within the care programme approach process and facilitated safe discharge. They had effective partnership working with the GP, hospitals, local community facilities, local authorities, and health commissioners.
- Staff told us that they had developed good working relationships with the local GP. The GP visited some of the patients on the unit who were unable to go to the surgery. Staff told us that information sharing and access was easy between internal and external professionals.
- We saw that community nurses, families, patients and external professionals attended patients' care programme approach meetings. Patients and their families told us that other professionals who were involved in their care and treatment attended their meetings.

Adherence to the MHA and the MHA Code of Practice

- Training records indicated that 85 % staff had received training in Mental Health Act (MHA) and the Code of

Requires improvement

Wards for people with learning disabilities or autism

Practice. Staff told us that they had not received any training in respect of the revised MHA Code of Practice. We could not find clinical policies had been updated to reflect the revised MHA Code of Practice.

- Twelve patients were detained under the 'Act' across the service for people with autism.
- The documentation we reviewed in detained patients' files was up to date, stored appropriately and compliant with the Mental Health Act and the Code of Practice.
- Consent to treatment and capacity forms were completed and attached to the medication charts of detained patients. The hospital used a form called "assessment of capacity to give valid consent" for treatment decisions. This form did not correctly set out the requirements of the Mental Capacity Act.
- Information on the rights of patients who were detained was displayed and independent mental health advocacy services were readily available to support patients. Staff were aware of how to access and support patients to engage with the independent mental health advocacy when needed.
- The explanation of rights was routinely conducted and audited regularly. The units made easy read leaflets available to patients. However, there were no additional attempts to illustrate or demonstrate the patient's detention and rights tailored to those patients with very limited communication skills. The patient's level of understanding was recorded. Where patients' level of understanding was not good, records showed that staff were regularly attempting to explain the rights.
- Staff knew how to contact the Mental Health Act administrator who was based at the hospital for advice when needed. There was no evidence that the provider carried out Mental Health Act audits.

Good practice in applying the Mental Capacity Act

- Training records showed that 84% of staff had received training in the Mental Capacity Act. Staff demonstrated a poor understanding of Mental Capacity Act and found it difficult to demonstrate how the five statutory principles could be applied in practice.
- Patients' capacity to consent was assessed and but not recorded in detail. These were done on a decision–specific basis for significant decisions. There was lack of detailed information on how capacity to consent or refuse treatment had been sought. We looked at four mental capacity assessments associated with the patients' finances in Whiston, which were carried out by the nurses. They lacked information on how a decision was reached to suggest that patients lacked capacity.
- Patients were supported to make decisions where appropriate. When patients lacked capacity, decisions were made in their best interests, recognising the importance of their wishes, feelings, culture and history. There was one very good example of a best interests meeting that involved the ambulance service and the acute NHS hospital to secure medical treatment for a patient who lacked capacity. However, one patient in Whiston, who was subject to DoLS, did not have a best interests meeting to consider ongoing treatment with psychotropic medication when the MHA no longer applied.
- Staff understood, and where appropriate, worked within the Mental Capacity Act definition of restraint.
- Staff knew the lead person to contact about Mental Capacity Act to get advice.
- Deprivation of Liberty Safeguards applications were made when required. Two patients in Whiston were subject to Deprivation of Liberty Safeguards.
- The arrangements in place were not effective and robust enough to monitor adherence to the Mental Capacity Act.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We observed good interactions between staff and patients. Staff spoke to patients in a way that was respectful, clear and simple and showed positive engagement and desire to support patients. We saw a new admission to Moneystone and staff took their time to interact with the patient at a level that the patient could understand. The interaction was pleasant and provided a positive and comforting welcome to the unit.
- Patients and families were complimentary about the support they received from the staff and felt staff

provided the help they needed. Our observations and discussions with patients and their families confirmed that they had been treated with respect and dignity. Staff were polite, kind and made them felt at home.
- Staff demonstrated an understanding of the basic needs of patients but struggled to describe how more complex needs around autism would be met.

The involvement of people in the care they receive

- We observed a patient shown around the unit on admission and introduced to staff and others. This patient had not been given the opportunity to visit the place before an admission was agreed due to distance involved from previous placement. Other relatives and patients told us that they had visited prior to admission.
- Our observation of practice, review of records and discussions with patients and their relatives confirmed that patients were actively involved in their clinical reviews, care planning and risk assessments and were encouraged to express their views. The units invited patients to participate in the care programme approach and clinical reviews. We attended two clinical reviews and patients and their relatives were given time to express their views. Their views were taken into account and they were happy about the way they were involved in care discussions. Staff told us that due to difficulties in communication with most of the patients an individualised patient preferred method of communication was used. This helped to make the most of individual communication methods to generate the views of patients with complex needs. The individual patient responses were fed back to staff, to enable them to make changes where needed.
- Staff were aware how to access advocacy services for patients. Where a patient lacked capacity an automatic referral was made to the advocacy service. Staff gave families, carers and patients leaflets that contained information about advocacy services. Patients and their families told us that they could to access advocacy services when needed.
- Staff gathered the views of relatives and families through questionnaires and family and carers' forums. The results were analysed to make any necessary changes. The manager told us that they had started to run a family and carers' forum every six months. Staff also told us that their views were listened to in clinical review meetings and relatives were free to contact them any time to discuss their views.
- Staff did not record patients' advance decisions. These are decisions made by patients how they would like to be treated in the future. The manager told us that they were going to act on that to ensure that where appropriate this would be recorded.

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

(for example, to feedback?)

Requires improvement

Access and discharge

- The average bed occupancy was 83% over the last six months.
- Referrals usually came from commissioners for patients requiring a more secure environment. The patients included out of area placements, all patients had received care, and treatment reviews within the last 12 months. The discharge plans were discussed at the first clinical review of each patient after admission.
- Each individual patient's stay was monitored through their annual care and treatment reviews. Staff told us that because of the complex needs of the patients they admitted at times it was difficult to discharge patients within the periods anticipated.
- Patients on leave could access their own beds on return from section 17 leave.
- Patients were only moved to another unit for clinical reasons. All patients were admitted to either Moneystone or Whiston and were moved to Highcroft if their needs had changed after a period of assessment and treatment.
- The unit worked closely with the care managers, commissioners and local authorities to ensure that patients were helped through their discharge. All discharges and transfers were discussed in the multi-disciplinary team meeting and were managed in a planned or co-ordinated way.
- If a patient required more intensive care that could no longer be safely managed on the unit, the care manager and commissioners would be contacted to find a suitable placement.

- At the time of our inspection, there were no delayed discharges in the past six months.

The facilities promote recovery, comfort, dignity and confidentiality

- Moneystone and Whiston had rooms where patients could sit quietly, relax and watch TV or engage in therapeutic activities. Highcroft did not have a quiet room where patients could sit quietly. All units had an occupational therapy kitchen where patients could go in and make drinks with staff. Whiston had a sensory room that was used for patients to relax and listen to music.
- Moneystone and Highcroft lacked access to sensory activities and equipment. Staff told us that patients could access facilities in Whiston if the ward was settled. There were no photographs or symbols displayed to help orient patients to the environment. Staff on duty lists and activities timetables were not presented in a visual form to support patients' understanding. This did not recognise the needs of patients with autism who were thought to be visual learners. Information presented in a visual way could help to encourage and support patients' communication, language development and ability to process information. We saw a file of easy read materials in the staff offices but this was not related to specific patient communication needs.
- The units had clinic rooms but had no examination room with couch to examine patients. The manager told us that they encouraged all patients to visit their GP surgery and where patients were unable to visit, they were examined in their bedrooms.
- There was a designated room in the main offices building where patients could meet visitors in private away from the patient area.
- Patients could make phone calls in private. Some patients had their own mobile phones.
- The units had access to outdoor areas, which included a smoking area which patients had access to throughout the day with staff supervision.
- Patients had access to hot drinks and snacks anytime of the day. Some patients had supervised access to the kitchen where they could make their own drinks. Staff told us that this was assessed on an individual basis and as patients progressed; their level of independence was increased according to risk assessment.
- Patients were able to personalise their own bedrooms. A patient in the long-term segregation had been provided with padded walls and soft furnishings to limit self-injury. The room had a light projector and a switchboard to provide entertainment. It was clearly designed to meet the individual's needs.
- Each patient had an individual bedroom fitted with a solid door. Their valuables were secured in the staff office.
- There was a range of activities offered to patients in all wards. Each patient had an individual programme of activities that was not firmly structured. For example, it only identified three activities for the whole day. Patients, relatives and staff told us that activities were very limited on weekends and evenings. Limited input from occupational therapists resulted in lack of meaningful and purposeful activities that promoted independent living skills. The activities appeared to focus more on leisure.

Meeting the needs of all people who use the service

- The units had assisted bathrooms for patients with mobility issues. Moneystone had a lift.
- The units had information leaflets about the service provided. However, this information was not available in an easy-read format.
- Interpreting services were available when needed to meet the needs of people who required additional help to communicate when receiving care and treatment. These were obtained from external services.
- Patients and their families were provided with limited information leaflets, which were specific to the service provided. Patients did not have access to relevant information about topics such as treatment guidelines, conditions, advocacy, patient's rights and how to make complaints in an easy-read format.
- Staff used Makaton to help individuals communicate their needs. Staff reported that training on communication needs was limited.
- All units offered and supported patients with the choice of food they wanted to meet their dietary requirements and meet their religious and ethnic needs.
- All patients had 'my shared pathway' where a summary of the patient's needs were highlighted, such as likes and dislikes, activities, cultural, religious, ethnic and spiritual needs. All of these were discussed with the patient and family, where appropriate.

Requires improvement

Wards for people with learning disabilities or autism

- There were contact details for representatives from different faiths. Patients were supported to meet their spiritual needs. There was no dedicated multi-faith room on site.

Listening to and learning from concerns and complaints

- The units received eight formal complaints between August 2014 and July 2015. Three of the complaints were upheld.
- Information on how to make a complaint was displayed in the units. Patients could raise concerns with staff anytime. Families and carers told us that they were able to raise any concerns and complaints freely. Some family members informed us that they were not aware of the formal complaints procedure. However, they said they could raise concerns directly with manager and felt listened to.
- Staff told us they tried to resolve patients' and families' concerns informally at the earliest opportunity. We observed that staff responded appropriately to concerns raised by relatives and carers of patients and received feedback. Staff were aware of the formal complaints process and knew how to support patients and their families when needed.
- Our discussion with staff and the records we observed showed that any learning from complaints was shared with the staff team through handovers and staff meetings.

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

Requires improvement

Vision and values

- Staff understood the vision and values of the broader organisation and agreed with the values. The vision and values of the organisation were displayed in the units. The organisation aimed to deliver the highest level of recovery focussed care in a planned and therapeutic approach for patients with complex autism.
- In view of the Winterbourne review, the hospital developed a model of service delivery. The team identified and planned the delivery of care for patients with complex autism to adopt a pathway approach where patients were encouraged to move towards the community. The aim was for patients to gain as high a level of functioning as possible and to move on from The Woodhouse to a community based location within the shortest possible time.
- Staff spoken with did not demonstrate a good understanding of their service's objectives. Staff reported receiving mixed messages from senior management about the aims and objectives of the service. Staff told us they understood that they provided a specialist autism service but were told by their service manager that they are not a specialist service. Staff knew who their senior managers were and told us that these managers visited the units.

Good governance

- The units had governance processes to manage quality and safety. The units used these methods to give information to senior management in the organisation to monitor their quality and safety. However, the governance processes were not effective and robust enough to ensure that quality and safety of the service is always maintained. The areas identified by the inspection team as not monitored effectively were emergency equipment, MHA training, access to medical staff out of hours, staff supervision,, staff morale, infection control and food hygiene procedures, meaningful and purposeful activities and the effectiveness of autism training.
- All information collected was analysed to develop themes and this was measured against set targets. The hospital manager held a clinical governance meeting each month. The service managers also attended the organisation's clinical governance meeting where quality and safety issues were discussed.
- In addition to clinical governance meetings, there were weekly incident review meetings and monthly health and safety meetings. The weekly incident review meetings provided timely feedback, changes to care planning, and risk assessments to all staff. The information that had been analysed for trends and themes was shared with staff to tell them how the unit was performing, for example, the number of incidents reported, the episodes of restraint and safeguarding. Where performance did not meet the expected standard, action plans were put in place.

Requires improvement

Wards for people with learning disabilities or autism

- The service managers felt they were given the freedom to manage the units. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the hospital's risk register.

Leadership, morale and staff engagement

- The annual average for qualified sickness absence was 7.2% across the hospital as at 30 September 2015. For support staff sickness the annual average was 7.6% as at 30 September Combined annual turnover for Qualified and Support staff as at 30 September 2015 across the hospital was 38.5%
- There were no grievances being pursued, and there were no allegations of bullying or harassment.
- Staff told us that they were aware of the organisation's whistleblowing policy and that they felt free to raise concerns, and said they would be listened to.
- Staff told us that they felt supported by their line manager and were offered opportunities for clinical and professional development.
- Staff told us that morale within the team varied in accordance with the complex needs of the patients they worked with. They told us that most of the staff did not want to work within these units as they found it very challenging and stressful. The hospital manager told us that they recognised the stress of working in an acute environment. They had arranged additional staff support through stress management training and would rotate staff around the units. Staff spoke positively about their role and demonstrated their dedication to providing high quality patient care. They told us that staff supported each other within the team.
- Staff reported different experiences of senior management support. Some said that managers were accessible, promoted an open culture, invited new ideas on how to improve the service and were willing to share ideas. Other staff told us that the managers were not very approachable and supportive. For example, staff expressed concern over being able to take breaks, access to a staff toilet during working hours, a fear of taking sickness absence, and the rates of pay, and said they were not being addressed.
- Staff were open and transparent when things went wrong. Incidents were discussed with patients, their families and care managers. Patients, families and care managers told us that they were informed and given feedback about things that had gone wrong.
- Staff told us the senior management team informed them about developments through emails and intranet and sought their opinion through the annual staff surveys.

Commitment to quality improvement and innovation

- The unit had not participated in any quality improvement programmes such as accreditation for inpatient learning disability services from the Royal College of Psychiatrists or had been involved in any research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is enough emergency equipment such as automated external defibrillators and oxygen cylinders and that it is kept in good working order.
- The provider must ensure that staff practice good infection control procedures and food hygiene to protect patients and staff against the risks of infection.
- The provider must ensure that the units have nurse call systems to allow patients to call for help when needed.
- The provider should ensure that staff are trained in the revised Mental Health Act Code of Practice and that there are effective and robust arrangements in place to monitor adherence to the Mental Health Act and Mental Capacity Act.
- The provider must ensure that staff have a good understanding Mental Capacity Act and adhere to good practice in applying the Mental Capacity Act.
- The provider must ensure that the needs of patients with autism are met through effective communication and the environment that supports care and treatment for this patient group. Information about services is available in an easy read format.
- The provider must ensure that the leadership is able to support staff with their concerns, offer opportunities for clinical and professional development and set clear aims and objectives for the autism service.
- The provider must ensure that the governance processes to manage quality and safety are effective to monitor and address all areas of quality and safety.

Action the provider SHOULD take to improve

- The provider must ensure that staffing levels are adequate to ensure that patients' section 17 leave and activities are not cancelled and staff can have appropriate breaks during their shifts.
- The provider should ensure that staff receive both management and clinical supervision as appropriate according to the organisation's policy. There should be clear differentiation between the two types of supervision in practice, recording and the monitoring of compliance.
- The provider should ensure that patients in long-term segregation have independent reviews taking place.
- The provider should ensure that the medical staff on call can get to the hospital immediately when required.
- The provider should ensure that staff receive training that gives them the skills and knowledge to care for patients with autism.
- The provider should ensure that patients' advance decisions are recorded.
- The provider should ensure that information around the units is presented in a visual way to help to encourage and support patients' communication.
- The provider should ensure that information about services is available in an easy read format.
- The provider should ensure that the units have access to an examination room with couch to examine patients.
- The provider should ensure that patients have access to meaningful and purposeful activities throughout the week including weekends and evenings.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff must receive appropriate training to enable them to carry out the duties they are employed to perform. Staff did not receive training in the revised Mental Health Act Code of Practice. This was a breach of Regulation 18(2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider must assess, monitor and improve the quality and safety of the services provided. The governance processes to manage quality and safety were not effective to monitor and address all areas of quality and safety. The provider did not set clear aims and objectives for the autism service. The managers did not support staff with their concerns. This was a breach of Regulation 17(2)(a)(e)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider must ensure that the premises and equipment used are safe for their intended purpose.

The hospital did not have enough emergency equipment such automated external defibrillators and oxygen cylinders that was regularly checked to ensure that it was in good working order. The units were not fitted with nurse call systems to allow patients to call for help when needed. Staff in Whiston and Moneystone did not practice good infection control procedures and food hygiene to protect patients and staff against the risks of infection.

This was a breach of Regulation 12(2)(d)(e)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The care and treatment must only be provided with the consent of the relevant person, the registered person must act in accordance with MCA 2005. Staff had a limited knowledge of the MCA 2005. Mental capacity assessments for finance-related matters were not properly carried out. One patient did not have a best interests meeting to continue taking their psychotropic medication. This was a breach of Regulation 11(1)(3)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of patients must be appropriate and meet their needs.

This section is primarily information for the provider

Requirement notices

The autism wards did not have individual communication styles/preferences in place and the environment was adapted to meet the needs of patients. It did not have visual displays to help patients with autism understand their environment.

Patients were not given information in the most suitable way that they could understand. This was a breach of Regulation 9(1)(a)(b)(3)(g)