Jeesal Cawston Park

Quality Report

Jeesal Cawston Park
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Date of inspection visit: 20 - 21 June, 5 and 16 July 2019
Date of publication: 16/09/2019

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	Inadequate
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Inadequate
Are services well-led?	Inadequate

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

We rated Jeesal Cawston Park as inadequate because:

- The hospital was not working to the model of an assessment and treatment unit and therefore its operation was not in line with the expectations of the Transforming Care Programme. The service was not proactive in enabling patients to leave hospital and return to life in the community. Some patients who had been resident at the hospital for some years had no discharge plan.
- The provider had not ensured there were sufficient staff with the appropriate skills and training to deliver safe and effective care and treatment to patients. A high proportion of staff were unqualified support workers and, because of a high number of vacant posts, a substantial proportion of shifts were filled by bank or agency staff. Managers had not mitigated the risk this posed by ensuring that all staff had the training essential to provide high quality care to patients with complex needs in specialist setting. Also, the provider had not ensured there were sufficient staff on duty to complete patient observations in accordance with their policy.
- Staff did not always ensure that patients nursed within long term segregation were nursed in accordance with the Mental Health Act Code of Practice guidelines.
- Staff did not consistently complete physical observations of patients following restraint.
- Staff carried out weekly emergency bag checks but there was no assurance or system in place that the emergency bag would be checked after each use or between these times. Clinic rooms were not all fully equipped. Staff had not accurately checked the emergency equipment. We found no cleaning records in any of the clinic rooms or a clinic room audit in one of the clinic rooms.
- The service had not considered and responded to the needs of patients with autism in the ward environment. The service did not have any sensory rooms for patients and sensory equipment was minimal and not readily available for patient use.
- Staff did not ensure care and treatment records contained information on the patients' mental capacity. We found no individualised assessments of capacity for specific decisions within patient records with the exception of the use of medication.
- Managers were not proactive in identifying and responding to issues within the service. Managers responded to issues when identified by external stakeholders and then did not do so promptly. Managers were not consistently responsive to patient needs. Managers did not have a good understanding of the service they managed.
- The provider did not have an effective audit process to provide assurance or review the quality of the care provided at this hospital. There were poor governance arrangements in place to review audit processes. External stakeholders found issues that were not identified by the provider's internal or external audits.

However:

Summary of findings

- Managers requested bank and agency staff who were familiar with the service. Managers gave each new member of staff a full induction to the service before they started work, including bank and agency staff. The ward manager could adjust staffing levels according to the needs of the patients.
- All patients had their physical health reviewed regularly during their time on the ward. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff made sure that patients had access to physical healthcare, including specialists as required.
- The ward complied with guidance on the elimination of mixed sex accommodation. Each patient had their own bedroom with an en-suite bathroom, which they could personalise. The service had quiet areas and a room where patients could meet with visitors in private. Each ward had an outside space that patients could access easily.
- Patients could make their own hot drinks and snacks and were not dependent on staff. The service offered a variety of good quality food and patients told us they liked it.
- Managers were visible in the service and supported staff. Staff felt respected, supported and valued. Staff knew how to use the whistleblowing process and felt they could raise concerns without fear of victimisation.

Summary of findings

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Inadequate

Jeesal Cawston Park

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

Summary of this inspection

Background to Jeesal Cawston Park

Jeesal Cawston Park provides a range of assessment, treatment and rehabilitation services for adults with learning disabilities and autistic spectrum disorder. The patients receiving care and treatment in this service have complex needs associated with mental health problems and present with behaviours that may challenge.

The service is registered with CQC for the assessment or medical treatment for persons detained under the Mental Health Act 1983, and the treatment of disease, disorder and injury.

There are 57 registered beds. As part of our inspection we visited all wards:

• The Grange – a 15 bedded locked ward accepting male patients only

• The Lodge – a 14 bedded locked ward accepting both male and female patients

• The Manor – a 16 bedded ward which accepts both male and female patients

• The Manor Flats – has six individual living flats, where patients are supported to live independently

• The Yew Lodge - has three self-contained flats, where patients are supported to live independently

• The Manor Lodge – has three self-contained flats, where patients are supported to live independently.

There was not a registered manager in place at the time of our follow up inspection. However, the provider had recruited to this post and was proceeding with Care Quality Commission registration. Interim senior management arrangements were in place.

Since January 2015 we have inspected the provider eight times inclusive of this inspection. We have completed four comprehensive inspections as part of our ongoing comprehensive mental health inspection programme and have completed four focussed inspections following a number of concerns raised to the Care Quality Commission between these times.

There were 43 patients in the hospital when we inspected. One patient was informal, eight were subject to Deprivation of Liberty Safeguards (where a person's freedom is restricted in their best interests to ensure they receive essential care and treatment) and 34 were detained under a section of the Mental Health Act.

Our inspection team

The team that undertook the initial visit to the service in June 2019 comprised a Care Quality Commission inspection manager, four Care Quality Commission inspectors, a specialist advisor (nurse) with experience in physical health needs and patients with a learning disability detained under the Mental Health Act and an expert by experience.

We carried out a desktop review of the provider within 14 days of the inspection which identified the need for a follow up visit.

The team that undertook the follow up visit in July 2019 comprised two Care Quality Commission inspection managers and four Care Quality Commission inspectors.

Why we carried out this inspection

We carried out an initial unannounced focussed inspection following a number of concerns raised to the Care Quality Commission about the care and treatment of patients at Jeesal Cawston Park. This included concerns raised by Care Quality Commission staff who visited the hospital as part of the thematic review of restraint, seclusion and segregation. We carried out a desktop review to review additional information we requested from the provider and we also received additional intelligence about a significant management

Summary of this inspection

change. We then carried out a follow up unannounced focussed inspection to gather additional evidence since the management changes and we had received additional intelligence about the provider.

How we carried out this inspection

We have reported in the following domains:

- Safe
- Effective
- Caring
- Responsive
- Well led

This was a focused inspection. We looked at specific key lines of enquiries in line with information received prior to our inspection. Therefore, our report does not include all the headings and information usually found in a comprehensive report.

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visits, the inspection team:

- visited all six wards on site to look at the quality of ward environments and observed how staff were caring for patients
- spoke with 16 patients who were using the service
- spoke with two ward managers
- spoke with 15 other staff members including registered nurses, health care workers, a consultant psychiatrist, occupational therapist, speech and language therapist and assistant psychologists
- received feedback about the service from South Norfolk NHS Clinical Commissioning Group
- observed seven interactions and episodes of care
- examined in detail the care and treatment records of 13 patients
- examined in detail five positive behaviour support plans
- examined in detail seven incident forms
- examined in detail 17 patient medication records
- looked at a range of internal audits, policies, procedures and other documents relating to the running of the service.

During the desk top review, the inspection team examined the additional evidence requests sent in from the provider including:

- one patient's communication care plan
- one patient's communication passport
- 13 easy read care plans for two patients
- all patients' legal status
- staff training records
- staffing establishment
- vacancy rates
- bank and agency usage.

What people who use the service say

- We spoke with 16 patients. Fifteen patients spoke positively about staff.
- Five patients told us they felt staff were genuinely interested in helping them and cared for their wellbeing.
- One patient told us they did not feel safe because of other patients on the wards. Two patients told us they felt safe most of the time.
- Two patients told us they were not involved in writing their care plans. Five patients told us they knew of their care plan but did not have a copy. However, one patient told us they were involved in writing their care plan and two patients told us they had a copy of their care plan.
- Patients told us about external activities they had been on. However, one patient described in-house activities as boring. One patient told us that weekends

Summary of this inspection

were boring and there was not enough staff or enough to do. One patient told us they did not get to do the things they wanted. One patient told us they were not aware of their activity timetable.

- Patients told us they liked the food.

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:

- The provider had not ensured there were sufficient staff with the appropriate skills and training to deliver safe care and treatment to patients. The provider had not ensured there were sufficient staff on duty to complete patient observations in accordance with their policy.
- Staff did not ensure seclusion rooms complied with the Mental Health Act Code of Practice. Two-way communication was not working in The Lodge seclusion room on our follow up visit, and the temperature gauge was not accessible to staff in The Grange seclusion room.
- Staff did not always ensure patients nursed within long term segregation were nursed in accordance with the Mental Health Act Code of Practice guidelines. There were many gaps in the reviews of patients that are required to safeguard patients in segregation and protect their rights.
- Staff had not identified all risks on the environmental risk assessment of one of the wards.
- Staff carried out weekly emergency bag checks but there was no assurance or system in place that the emergency bag would be checked after each use or between these times. Staff had not accurately checked the emergency equipment. We found additional items than those recorded on the emergency bag checklist. We found out of date items despite weekly checks stating they were in date. Whilst there was an emergency bag checklist, it was not specific to the items we would expect to have in the emergency equipment bag.
- Staff did not consistently complete physical observations of patients following restraint. We reviewed seven incident forms. Incident forms required staff to take patient observations after staff restrained the patient. Staff had not carried out physical or visual observations of patients in three out of four cases where staff restrained the patient. Where staff had restrained the patient during these incidents we found no outcome to the restraint had been recorded. This meant that no investigations could take place or lessons learned could be shared.
- Clinic rooms were not all fully equipped. The Manor clinic room did not have ligature cutters and there was no contingency plan

Summary of this inspection

in place for an emergency. We found no cleaning records in any of the clinic rooms. The Lodge clinic room had no clinic room audit and two open sharps bins which were both full and unlabelled.

However:

- The service complied with guidance on the elimination of mixed sex accommodation.
- Staff had easy access to alarms and/or radios to summon help and patients had easy access to nurse call systems.
- Managers requested bank and agency staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The ward manager could adjust staffing levels according to the needs of the patients.
- Staff completed a risk assessment for each patient. Staff reviewed and updated patient risk assessments regularly.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Managers did not make sure all staff received specialist training for their role including Makaton and mental health and learning disabilities training which is necessary for this patient group.
- Staff did not follow best practices when assessing and recording patients' mental capacity. They did not ensure care and treatment records contained information on patients' mental capacity. We reviewed 17 patient medication records across two visits to the provider. All patients had capacity assessment forms completed in relation to the use of medication. Nine out of 17 patients lacked capacity. Five out of nine capacity assessment forms for patients who lacked capacity had not been updated in the 18 months prior to inspection, one of the forms had not been updated in the previous two years.
- The provider had not followed their own or legal processes effectively when putting in place a patient's Do Not Attempt Resuscitation form. An external stakeholder told us they had reviewed a patient's 'Do Not Attempt Resuscitation" form a week prior to our inspection. They found that neither a mental capacity assessment nor a best interest meeting had been held and the Do Not Attempt Resuscitation form was therefore invalid. This meant that staff would not know that resuscitation would be needed. However, the provider told the external stakeholder they had rescinded the Do Not Attempt

Summary of this inspection

Resuscitation form until legal processes could be followed. We checked this during our inspection and we did not find any documentation relating to the Do Not Attempt Resuscitation form.
- We found no evidence of patient involvement in writing their care plans. Care plans did not contain an active patient voice.
- We reviewed multiple easy read care plans for two patients. We reviewed the same two patients' communication plans. Based on the information present in the patient's communication plans the patients would not be able to understand their easy read care plans.

However:

- Staff ensured all patients had their physical health regularly reviewed during their time on the ward. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff made sure patients had access to physical healthcare, including specialists as required. Staff identified patients' physical health needs and recorded them in their care plans.
- The service had access to a range of specialists to meet the needs of the patients on the ward. Staff provided a range of treatment and care for patients based on national guidance and best practice.
- Staff understood patients' positive behavioural support plans and provided the identified care and support.
- Managers gave each new member of staff a full induction to the service before they started work.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- We found insufficient evidence that staff consistently involved patients in their care planning. Two patients told us they were not involved in writing their care plans and five told us they knew of their care plan but did not have a copy.

However:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Staff were discreet and respectful when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Staff understood and respected the individual needs of each patient. We observed kind and positive interactions between staff and patients on the wards.

Summary of this inspection

Are services responsive?

Inadequate 

We rated responsive as inadequate because:

- The provider was not proactive in planning or seeking future placements for patients. We were told by the provider that they did not start looking for a placement for the patient until the patient was identified as ready for discharge. The provider sent us various conflicting items of information which failed to give assurance that the provider kept accurate records of delayed discharge and appropriately and proactively carried out discharge planning. Patients did not have discharge care plans or clear discharge pathways. Information relating to patients' discharges was not clearly documented. In two patient records, the provider had recorded that no future placements were being sought because the patients' needs were best met in the current placement. Both of these patients had been inpatients with the provider for between five and six years. One of these patients had goals set within their discharge plan to be discharged from the hospital and a placement was being actively sought.
- The service had not considered and responded to all the needs of patients with autism in the ward environment. The service did not have any sensory rooms for patients and sensory equipment was minimal and not readily available for patient use.
- Some patients were unable to communicate verbally and used pictorial exchange communication aids and Makaton (a form of sign language) to communicate with staff. However, signs and symbols were not readily available around the wards or on display to assist patients.
- Each ward had a hub information screen with information for staff and patients, but the words displayed on the screens were not easy to read or accessible.

However:

- Each patient had their own bedroom with an en-suite bathroom, which they could personalise. The service had quiet areas and a room where patients could meet with visitors in private. Each ward had an outside space that patients could access easily.
- Patients could make their own hot drinks and snacks and were not dependent on staff. The service offered a variety of good quality food and patients told us they liked it.
- Staff made sure patients could access information on their rights and how to complain. We saw easy read versions of these documents.

Summary of this inspection

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The hospital was not working to the model of an assessment and treatment unit and therefore its operation was not in line with the expectations of the Transforming Care Programme. The service was not proactive in enabling patients to leave hospital and return to life in the community.
- Managers failed to ensure that all staff had the training essential to provide high quality care to with patients with complex needs in a specialist setting.
- Managers did not have a good understanding of the service they managed. We found conflicting and contradicting information between managers and staff working on the wards.
- The provider did not have effective or robust governance in place to provide assurance or review the quality of the care provided at this hospital. There were poor governance arrangements in place to review staff practices and audits undertaken. External stakeholders found issues that were not identified by the provider's internal or external audits.
- Managers took part in clinical audits but these were not comprehensive and lacked detail. Clinical audits were recorded in paper files and on the providers electronic recording system. The paper files did not always reflect the electronic recording system. The paper files contained out of date information. Clinical audits were not comprehensive and lacked detail.
- Managers were not proactive in identifying and responding to issues within the service; including the individual needs of patients. Managers responded to issues when identified by external stakeholders and, not always promptly. One patient had been without their glasses for more than seven weeks because the provider had not communicated effectively. This had a significant impact on the patient's quality of life during this time.

However:

- Managers were visible in the service and supported staff. Staff felt respected, supported and valued. Staff knew how to use the whistleblowing process and felt they could raise concerns without fear of victimisation.
- Staff had access to the equipment and information technology needed to do their work.

Detailed findings from this inspection

Mental Health Act responsibilities

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

We did not review the provider's adherence to the Mental Health Act during this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not ensure care and treatment records, other than medication files, contained information on the patients' mental capacity. We found no individualised assessments of capacity for specific decisions within patient records. We saw evidence of patients with sleep apnoea who refused to wear their sleep apnoea machines at times who we did not see capacity assessments for.
- Staff did not review patients' mental capacity regularly. The Mental Capacity Act Code of Practice states "it is important to review capacity from time to time, as people can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some people (for example, people with learning disabilities) will learn new skills throughout their life, improving their capacity to make certain decisions. Assessments should be reviewed from time to time". We reviewed 17 patient medication records across two visits to the provider. All patients had capacity assessment forms completed in relation to the use of medication. Nine out of 17 patients lacked capacity. Five out of nine capacity assessment forms for patients who lacked capacity had not been updated in the last 18 months prior to inspection, one of the forms had not been updated in the last two years.
- An external stakeholder told us they had reviewed a patient's 'Do Not Attempt Resuscitation" form a few weeks prior to our inspection. They found that the form contained no clear rationale for this decision. They found the patient did not have capacity but there was not a capacity assessment in place for this decision. It had been documented on the Do Not Attempt Resuscitation form that the patient had been asked about their wishes and agreed that they did not wish to be resuscitated even though the patient did not have the capacity to make this decision. They found that the provider had not followed their own or legal processes effectively and that neither a mental capacity assessment nor a best interest meeting had been held and the Do Not Attempt Resuscitation form was therefore invalid. This meant staff would not know that resuscitation would be needed. However, the provider told the external stakeholder they had rescinded the Do Not Attempt Resuscitation form until legal processes could be followed. We checked this during our inspection and we did not find any documentation relating to the Do Not Attempt Resuscitation form.

Overview of ratings

Our ratings for this location are:

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

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

- Staff completed and regularly updated risk assessments of all ward areas, and removed, reduced or had mitigations for any risks they identified. However, staff had not identified all risks on the risk assessment in The Manor.
- Some of the wards had blind spots but these were mitigated by enhanced staffing observations.
- The ward complied with guidance on the elimination of mixed sex accommodation.
- Staff had easy access to alarms and/or radios to summon help and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

- All main ward areas were clean, well-furnished and fit for purpose. However, some areas looked dull, sparse and were in need of a paint refresh.

Seclusion room

- There were two seclusion rooms at the hospital; The Lodge and The Grange. Seclusion rooms allowed clear observation and had two-way communication. However, this was not working in The Lodge seclusion room on our follow up visit. This was immediately reported to managers. This had been an issue on two previous inspections; November 2018 and December 2017. We found the temperature gauge was behind a glass panel in The Grange seclusion room and set at 18 degrees. This was not accessible to staff, so they could not respond to patient needs if a patient requested for the temperature to be changed. We found issues around access to the controlled heating in The Lodge seclusion room in our November 2018 inspection. This shows the provider does not learn and carry across information from one scenario to another. Both seclusion rooms had a toilet and a clock. The provider had completed actions raised at our previous inspection which were to remove the raised screw coverings behind the toilet and to ensure that lighting could be subdued.

Clinic room and equipment

- Clinic rooms had resuscitation equipment. However, there was a lack of effective audit around the emergency bags. Staff carried out weekly emergency bag checks but there was no assurance or system in place that the emergency bag would be checked after each use or between these times. Staff had not accurately checked the emergency equipment. We found additional items than those recorded on the emergency bag checklist. We found out of date items despite weekly checks stating they were in date. We found one open lubricant tube with no date that it was opened, an absorbent dressing pad, an expired trauma dressing, an open oxygen mask and two out of date bandages. Whilst there was an emergency bag checklist, we could not be assured that staff knew what should and should not be in the emergency bag as it was not specific to the emergency equipment bag. The emergency bag checklist contained items not required in the emergency bag, such as a soap dispenser and blue paper towels.

- There were three clinic rooms across the site. Emergency drugs were accessible in clinic rooms. However, clinic rooms were not all fully equipped. The Manor clinic room did not have ligature cutters and there was no contingency plan in place for an emergency. We checked, and we could not find any ligature cutters located anywhere else in The Manor. The Grange clinic room had no couch where patients could lay or sit to have any physical observations carried out. We found no cleaning records in any of the clinic rooms and no clinic room audit in The Lodge. In The Lodge clinic room, we found two open sharps bins which were both full and unlabelled. We also found two open bottles with no labels on. This meant staff would not know when to throw out this medication, as per the instructions on the label, as they would not know when it had been opened. We found in The Manor clinic room that staff were recording fridge temperatures as high, but staff were not always recording actions taken in response to this.

Safe staffing

Nursing staff

- The provider had not ensured there were sufficient staff on duty to complete patient observations in accordance with their policy. The provider's observation and engagement policy stated that staff should not be involved in level three or four observations for the whole shift and should be rotated at regular intervals and for no longer that two hours. This was in recognition of the potential difficulty in maintaining concentration for more than this time. Staff were completing continuous observations, changing between patients, for up to 12 hours. Most staff had either an hour and a half break within this time or two 45-minute breaks which meant staff were completing continuous observations, changing between patients, for up to 9 hours. Not all staff were allocated breaks.
- The provider had not ensured there were sufficient staff with the appropriate skills and training to deliver safe care and treatment to patients. The provider reported an overall vacancy rate of 44% for registered nurses at the time of the inspection. The overall vacancy rate for senior support workers was 8% and the overall vacancy rate for support workers was 39% at the time of the inspection. Between 1 March 2019 and 31 May 2019 of the 9632 total shifts available, 13.1% were filled by bank staff to cover sickness, absence or vacancy for all staff. In the same period, agency staff covered 18.9% of available shifts for all staff. Managers requested bank and agency staff familiar with the service.
- Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.
- Managers tried to use long term agency staff for consistency for the patients who knew the patients well.
- The ward manager could adjust staffing levels according to the needs of the patients.
- Patients told us they rarely had their escorted leave, or any activities cancelled.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed a risk assessment for each patient. Staff reviewed and updated patient risk assessments regularly.

Management of patient risk

- Managers had not ensured all staff were aware of patients' risks before allocating staff to observe patients. The provider's observation policy stated the delegated member of staff must know who they are to observe and understand what risks they are observing. Prior to commencing observations, they should familiarise themselves with the patient's nursing treatment and support plan. We spoke to one staff member who was on one to one patient observations and was unaware of the patient risk or the reason for this observation. This meant that this could impact patient safety.
- Staff adhered to best practice in implementing a smoke-free policy. Staff held smoking cessation classes weekly.

Use of restrictive interventions

- Staff did not always ensure patients nursed within long term segregation were nursed in accordance with the Mental Health Act Code of Practice guidelines. Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multidisciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or

unit on a long-term basis. Four patients were in long term segregation at the hospital at the time of our inspection. We found multiple gaps in two patients' 24-hour reviews. These gaps were often over the weekends. The Mental Health Act Code of Practice states that "the patient's situation should be formally reviewed by an approved clinician who may or may not be a doctor at least once in any 24-hour period and at least weekly by the full multidisciplinary team". We found 23 gaps within two patients 24-hour long term segregation reviews of between two and eight days. We found two gaps of two days, six gaps of three days, ten gaps of four days, three gaps of five days, one gap of six days and one gap of eight days.

- The Mental Health Act code of Practice states "where long-term segregation continues for three months or longer, regular three-monthly reviews of the patient's circumstances and care should be undertaken by an external hospital". We found two gaps within one patient's three-monthly independent reviews over the 12 months prior to inspection and the most recent review should have been the month prior to our inspection which we found no evidence of. However, staff held weekly review meetings for these patients. We saw evidence of two patients being integrated back with their peers and into the ward environment and reviews were regularly held to discuss the integration of the third patient.
- The long-term segregation environment on one of the wards was not conducive to patient recovery. The environment looked tired, dirty, not homely and lacked any natural light and sense of space. Staff observed the patient through Perspex glass, however, this was badly scratched. All patients' in long term segregation had access to outside space, however, on one of the wards this was dark, small and lacked any feeling of being a natural garden or outside space. This was contradictory to the long-term segregation area on another ward which was bright, had more room and we observed a plan on wall next to the door of how to support the patient.

Safeguarding

- Managers had not ensured all staff were compliant with safeguarding adults training, in accordance with their own target of 90%. We were particularly concerned around required training for bank staff. At the time of inspection, the compliance with training for permanent registered nurses was 87.5%, and 74% for permanent support workers. The provider had not ensured bank staff or therapy staff were suitably trained. The compliance for bank nursing staff was 71.4%. The compliance for bank support workers and senior support workers was 39.2%. The compliance for the therapy team was 67.7% at the time of our inspection. This was of concern due to the high levels of bank staff working across the hospital.
- Four out of five staff we spoke with could tell us they knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Four out of five staff we spoke with told us they knew how to make a safeguarding referral and who to inform if they had concerns. One staff member told us they had been working at the provider for two months and had received safeguarding training but did not know the safeguarding procedure. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Staff access to essential information

- Staff had access to the equipment and information technology needed to do their work. Staff had access to portable tablet computers. They could input observations and effectively access patient care and treatment plans. Staff told us they discussed these with patients.
- Managers could use the electronic patient information system to send memorandum to all staff which would pop up on their screens when they logged in and would stay on screen until a box was ticked to say they had read the information. These memos could relate to information about incidents, lessons learnt or any information the staff needed to relay to each other. Staff also used the system to initiate and follow up maintenance requests.

Medicines management

- We reviewed 17 patient medication records across two visits to the provider. We reviewed seven medication records on our first visit and a further 10 records on the follow up visit.

Inadequate

Wards for people with learning disabilities or autism

- Staff did not review patients' capacity regularly. The Mental Capacity Act Code of Practice states "it is important to review capacity from time to time, as people can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some people (for example, people with learning disabilities) will learn new skills throughout their life, improving their capacity to make certain decisions. Assessments should be reviewed from time to time". We reviewed 17 patient medication records across two visits to the provider. All patients had capacity assessment forms completed in relation to the use of medication. Nine out of 17 patients lacked capacity. Five out of nine capacity assessment forms for patients who lacked capacity had not been updated in the last 18 months prior to inspection, one of the forms had not been updated in the last two years.
- Staff did not always follow best practice when recording medicines administration or recording information on medication charts. On our first visit we found three out of seven patients had not received medication as prescribed. Two of these patients had not been given their morning medications on the day of our inspection due to being in bed all morning. There were no processes in place to mitigate this. During the follow up visit we reviewed a random sample of another 10 patients' medication cards and there were no issues.

Reporting incidents and learning from when things go wrong

- Staff did not always follow the Mental Health Act Code of Practice or the provider's policy regarding restrictive intervention. Following restraint staff did not consistently complete physical observations for patients. We reviewed seven incident forms. Incident forms required staff to take patient observations after staff restrained the patient. Staff had not carried out physical or visual observations of patients in three out of four cases where staff restrained the patient. The incident forms stated this was because the patient either refused or was still distressed.
- Staff did not always debrief patients after incidents. Where staff had restrained the patient during these incidents we found no outcome to the restraint had been recorded. This meant that no investigations could take place or lessons learned could be shared.
- Staff used body maps to identify any injuries following an incident. This was part of the incident form staff completed. This had improved since our last inspection.
- All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report.
- Managers debriefed and supported staff after any serious incident.
- Managers shared learning from incidents on their electronic recording system and had processes in place to ensure staff read these on the electronic recording system.

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 reviewed 13 care and treatment records in detail on the provider's electronic recording system.
- All patients had their physical health regularly reviewed during their time on the ward. Staff used recognised rating scales to record patients' physical health.
- Staff developed care plans for each patient that met their mental health needs. Most care plans were personalised, holistic and recovery-orientated. However, we found unclear, inconsistent and contradictory wording within some patients' care plans, particularly around observation levels.
- Positive behaviour support plans were present and supported by a comprehensive assessment in most cases. A behaviour support plan is based on the results of a functional assessment and uses positive behaviour support approaches. The plan contains a range of strategies which not only focus on the challenging behaviour but also include ways to ensure the person has access to things that are important to them. However, two out of 13 patient care and treatment records we reviewed did not have a positive behaviour support plan. We looked at 11 positive behaviour support plans. We found all positive behaviour support plans were consistent.
- Staff did not ensure care and treatment records contained information on the patients' capacity. We

found no individualised assessments of capacity for specific decisions within patient records. We saw evidence of patients with sleep apnoea who refused to wear their sleep apnoea machines at times who we did not see capacity assessments for. However, we did find capacity assessments in relation to the use of medication only in patients' medication files.

- We reviewed multiple easy read care plans for two patients. We reviewed the same two patients' communication plans. Based on the information present in the patients' communication plans the patients would not be able to understand their easy read care plans. We were told nursing staff write patients easy read care plans and not therapy teams. Nursing staff are not trained to write easy read care plans.
- Staff regularly reviewed and updated care plans and positive behaviour support plans when patient's needs changed.
- We found no evidence of patient involvement in writing their care plans. Care plans did not contain an active patient voice. It was unclear if patients had a copy of their care plan.

Best practice in treatment and care

- Staff provided a range of treatment and care for patients based on national guidance and best practice. Patients had access to psychological therapies and speech and language therapists.
- Staff understood patients positive behavioural support plans, where available, and provided the identified care and support.
- Staff supported patients with their physical health and encouraged them to live healthier lives.
- Staff identified patients' physical health needs and recorded them in their care plans.
- Staff made sure patients had access to physical health care, including specialists as required.
- Staff used technology to support patients. Staff had access to portable tablet computers where they could input observations and access patient care and treatment plans.
- Managers took part in clinical audits; however, these were not comprehensive and lacked detail. Clinical audits were recorded in paper files and on the providers electronic recording system. The paper files did not always reflect the electronic recording system. The paper files contained out of date information.

Skilled staff to deliver care

- The service had access to a range of specialists to meet the needs of the patients on the ward.
- Managers did not make sure all staff received specialist training for their role. We were not assured all staff had appropriate training for their roles. We were particularly concerned around required training for bank staff. We asked the provider for training figures for all staff but the provider was unable to provide us with agency staff training figures. The compliance for mental health and learning disabilities training at the time of our inspection was 25% for managers, 62% for permanent support workers and senior support workers, 50% for permanent registered nurses, 37% for bank support workers and senior support workers and 73% for the therapy team. However, bank registered nurses who worked at the hospital did not receive this training.
- Some staff had access to positive behaviour support training. The compliance for positive behaviour support training at the time of our inspection was 100% for managers, 71% for permanent support workers and senior support, 100% for permanent registered nurses and 96% for the therapy team. However, bank staff who worked at the hospital did not receive this training.
- All staff had access to person centred support training. The compliance for person centred support training at the time of our inspection was 50% for managers, 64% for permanent support workers and senior support workers, 100% for permanent registered nurses, 100% for bank support workers and senior support workers, 43% for bank registered nurses and 24% for the therapy team.
- Some staff had access to autism awareness training. The compliance for autism awareness training at the time of our inspection was 100% for managers, 100% for permanent support workers and senior support workers, 100% for permanent registered nurses, 100% for bank support workers and senior support workers and 59% for the therapy team. However, bank registered nurses who worked at the hospital did not receive this training.
- Managers gave each new member of staff a full induction to the service before they started work.

Good practice in applying the Mental Capacity Act

- Staff did not ensure care and treatment records contained information on the patients' capacity. We

found no individualised assessments of capacity for specific decisions within patient records. We saw evidence of patients with sleep apnoea who refused to wear their sleep apnoea machines at times who we did not see capacity assessments for. However, we did find capacity assessments in relation to the use of medication only in patients' medication files.

- Staff did not review patients' capacity regularly. The Mental Capacity Act Code of Practice states "it is important to review capacity from time to time, as people can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some people (for example, people with learning disabilities) will learn new skills throughout their life, improving their capacity to make certain decisions. Assessments should be reviewed from time to time". We reviewed 17 patient medication records across two visits to the provider. All patients had capacity assessment forms completed in relation to the use of medication. Nine out of 17 patients lacked capacity. Five out of nine capacity assessment forms for patients who lacked capacity had not been updated in the last 18 months, one of the forms had not been updated in the last two years.
- An external stakeholder told us they had reviewed a patient's 'Do Not Attempt Resuscitation" form a few weeks prior to our inspection. They found that the form contained no clear rationale for this decision. They found the patient did not have capacity but there was not a capacity assessment in place for this decision. It had been documented on the Do Not Attempt Resuscitation form that the patient had been asked about their wishes and agreed that they did not wish to be resuscitated even though the patient did not have the capacity to make this decision. They found that the provider had not followed their own or legal processes effectively and that neither a mental capacity assessment nor a best interest meeting had been held and the Do Not Attempt Resuscitation form was therefore invalid. This meant staff would not know that resuscitation would be needed. However, the provider told the external stakeholder they had rescinded the Do Not Attempt Resuscitation form until legal processes could be followed. We checked this during our inspection and we did not find any documentation relating to the Do Not Attempt Resuscitation form.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

- We spoke with 16 patients. Fifteen patients spoke positively about staff. However, one patient told us for the most part the staff are good but sometimes they can be very curt and almost nasty.
- One patient told us they did not feel safe because of other patients on the wards. Two patients told us they felt safe most of the time.
- One patient told us that a staff member had used a mobile phone whilst supporting them on a trip to make a personal call and left them alone in the vehicle for a period of time on the same trip. One patient told us that a staff member had fallen asleep on shift whilst supporting them. We reported both incidents to the provider at the request of the patient and received notifications from the provider the same day.
- Staff were not consistently responsive to patient needs. We found that a patient had been without their glasses for over seven weeks due to the provider not financially supporting the patient when requested. We reviewed the daily notes for this patient for a period of six months and found that being without glasses had an impact on their ability to attend meetings and we found increased evidence of headaches which the patient had reported to staff would happen.
- Most staff we spoke with understood and respected the individual needs of each patient. We spoke to one staff member who was on one to one patient observations and was unaware of the patient risk or the reason for this observation.
- Staff were discreet and respectful when caring for patients.
- Staff gave patients help, emotional support and advice when they needed it.
- We observed staff treating patients with compassion and kindness. They respected patients' privacy and dignity.
- We observed patients engaged with members of staff in a range of activities including indoor skittles, planning a shopping trip and during a barbeque. We observed kind

and positive interactions between staff and patients on the wards. We observed staff offering choice to patients. Staff communicated with patients using their preferred method of communication.
- Five patients told us they felt staff were genuinely interested in helping them and cared for their wellbeing.

Involvement in care

Involvement of patients

- Staff introduced patients to the ward and the services as part of their admission.
- Staff did not consistently involve patients in their care planning or give them access to their care plans. Two patients told us they were not involved in writing their care plans. Five patients told us they knew of their care plan but did not have a copy. However, one patient told us they were involved in writing their care plan and two patients told us they had a copy of their care plan.

Involvement of families and carers

- We spoke to three patients' relatives and carers. Two carers we spoke with were very positive about the provider and felt the staff informed and involved them in their relatives' care. One carer told us they had reported to the provider that one member of staff was asleep on duty. One carer said that their relative had been involved in a few safeguarding issues with another patient. One carer stated that the staff do not always communicate with them in a timely manner.

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

(for example, to feedback?)

Inadequate

Access and discharge

Bed management

- The mean duration of stay for patients calculated at the time of inspection was 954 days. Patients length of stay ranged from 19 days to 2890 days. We saw evidence within a patient's discharge plan that a joint decision had been made a few years previously with external stakeholders, and reviewed recently, stating that the patient's needs were best met at the current placement for the foreseeable future and therefore no future placements were being sought.

Discharge and transfer of care

- The provider was not proactive in seeking future placements for patients. We were told by the provider that they did not start looking for a placement for the patient until the patient was identified as ready for discharge. The Mental Health Act Code of Practice states "discharge planning for people with autism should begin when the person is admitted". Transforming Care for People with Learning Disabilities states patients "have an agreed discharge plan from the point of admission. The provider told us about seven patients identified ready for discharge whose placements are currently being actively sought by an external team, but none are currently identified. These patients have been identified as ready for discharge for between two and 16 months.
- We requested information from the provider about delayed discharges. The provider sent us various conflicting bits of information which meant we could not be assured the provider kept accurate records of delayed discharge and appropriately and proactively carried out discharge planning.
- Patients did not have discharge care plans or clear discharge pathways. Information relating to patients' discharges was not clearly documented. The provider told us patients' discharges were discussed in their Care Programme Approach meetings. We reviewed 15 Care Programme Approach meeting minutes for nine patients. We found proposed discharge timescales were unclear and had lapsed in three Care Programme Approach meetings and staff had not updated them. We found in two patient records that the provider had recorded that no future placements were being sought as the patients' needs were best met in the current placement. Both of these patients had been inpatients with the provider for between five and six years and had no goals set within their Care Programme Approach meetings to be discharged from the hospital. However, we reviewed six patients' discharge pathways and found conflicting information. We found one patient whose Care Programme Approach meeting minutes had stated no future placements were being sought as the patients' needs were best met in the current placement, however

they had discharge plans that stated discharge to the community had been actively sought for a long time. We found in the other patient's discharge plan that a joint decision had been made a few years previously with external stakeholders, and reviewed recently, stating that the patient's needs were best met at the current placement for the foreseeable future.

- Two of the six patients' discharge pathways we reviewed were written after the date we requested the information from the provider. Four out of six discharge pathways did not contain a date of when they were written so we were unable to see progression. Two of the six discharge pathways we reviewed contained goals the patient must meet for a period of six months but did not contain the patients' progression, so it was unclear where these goals were reviewed. One of the discharge plans we reviewed had goals set for the patient to achieve discharge, but it had been decided their needs were best met at the current placement.

The facilities promote recovery, comfort, dignity and confidentiality

- The design, layout, and furnishings of the ward did not create a therapeutic environment and was not suitable for specific needs of the patients. The service had not considered and responded to the needs of patients with autism in the ward environment. The service did not have any sensory rooms for patients and sensory equipment was minimal and not readily available for patient use. One of the ward lounges was covered wall to wall in books. However, the books were not suitable for the patient group. None of the books we looked at were accessible, easy read or suitable for the patient group. The provider told us on our follow up visit that they had had two specialist sensory companies come out to quote for a sensory room in one of their wards and this would be trialled in one ward before potentially being rolled out to the others. However, we observed one sensory garden for a patient with high sensory needs.
- Staff told us some patients had sensory needs, however, not all patients had a sensory assessment who required one. One patient with high sensory needs did not have a specific care plan to guide staff on how best to meet these needs.
- Each patient had their own bedroom with an en-suite bathroom, which they could personalise.
- The service had quiet areas and a room where patients could meet with visitors in private.
- Patients told us about external activities they had been on. However, one patient described in house activities as boring. One patient told us that weekends are boring and there is not enough staff or enough to do. One patient told us they did not get to do the things they wanted to. One patient told us they were not aware of their activity timetable. We observed staff playing a game of skittles in the evening with patients and we observed staff having a service wide barbeque for patients at lunchtime. Patients told us this was taking place the day before.
- Each ward had an outside space that patients could access easily.
- Patients could make their own hot drinks and snacks and were not dependent on staff.
- The service offered a variety of good quality food and patients told us they liked it.

Patients' engagement with the wider community

- Staff supported patients to access leisure activities off site.

Meeting the needs of all people who use the service

- Some patients were unable to communicate verbally and used pictorial exchange communication aids and Makaton (a universal form of sign language) to communicate with staff. However, the provider had not ensured signs and symbols were readily available around the wards or on display to assist patients.
- Each of the main wards had a hub information screen with information for staff and patients. However, the words displayed on the screens were stretched, not easy to read or accessible. There was a lot of information displayed on some of the screens which changed quickly making it difficult to read. Information on the screens was written in English only and we did not see information displayed in other languages around the site. The self-contained flats did not have access to information screens and there were no information leaflets on display.
- Staff made sure patients could access information on their rights and how to complain. We saw easy read versions of these documents.

Inadequate

Wards for people with learning disabilities or autism

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

Inadequate

Leadership

- At the time of the first visit the provider had recently recruited some new leaders. A new managing director, quality lead, consultant learning disability specialist nurse, physical healthcare lead and all ward manager posts had been appointed to. Between our first inspection visit and our follow up visit two senior managers left their posts and the hospital had already begun the process of filling these vacancies. Interim senior management arrangements were in place.
- Managers were not proactive in identifying and responding to issues within the service. Managers responded to issues when identified by external stakeholders. Managers did not respond in a timely way to external stakeholders.
- Managers were not consistently responsive to patient needs. Managers had not followed their internal escalation process and the managers had not picked this concern up in their own internal audits. We found that a patient had been without their glasses for over seven weeks due to the provider not financially supporting the patient when requested which adversely impacted on the patient's health. A manager told us there had been mis-communication between staff and an order was placed the day of our inspection and the situation would be rectified within seven days.
- Managers did not have a good understanding of the service they managed. We found conflicting and contradictory information between managers and staff working on the wards. For example, how lessons learned were shared. We requested information from the provider about delayed discharges. The provider sent us various conflicting bits of information which meant we could not be assured the provider kept accurate records of delayed discharge and appropriately and proactively carried out discharge planning. We also found conflicting information between patients' Care Programme Approach meeting minutes and their discharge pathways.
- Staff told us managers were visible in the service and supportive.

Culture

- Staff felt respected, supported and valued. Staff knew how to use the whistleblowing process and felt they could raise concerns without fear of victimisation.

Governance

- The hospital was not working to the model of an assessment and treatment unit and therefore its operation was not in line with the expectations of the Transforming Care Programme. The service was not proactive in enabling patients to leave hospital and return to life in the community.
- The governance structures in place were not consistent or robust to provide adequate oversight and monitoring of quality, safety of services provided. The provider held governance meetings. Although regular dates were set for these meetings if the meetings did not take place the provider did not rearrange these for another suitable time. We reviewed three of the most recent meeting minutes. It was not clear where actions were set or who was responsible for each action. There was not a timeframe set for each action. Actions carried on across multiple meeting minutes as 'ongoing' without a timeframe for completion.
- The provider did not have an effective audit process to provide assurance or review the quality of the care provided at this hospital. There were poor governance arrangements in place to review audit processes. We found a number of examples. Staff completed a weekly emergency equipment audit where staff had signed to say items were in date, however, we found items that were out of date, two items for over six months. Shortly prior to the first inspection visit, the provider alerted us of a significant error in which a patient received the wrong dose of medication for a four-week period. This was not initially identified by the provider's internal or external audits but by an outside stakeholder. The pads for a defibrillator were used for staff training which meant there were none available in the event of an emergency. This was reported to the provider by an external stakeholder but had been rectified on our inspection visit. None of this had been identified in the providers internal or external audits. The audit forms showed what the issue was but not when it was resolved. Managers' monthly care plan audits were not

effective. Monthly reviews were absent of any useful information which can be used in the evaluation of effectiveness of the support plan and made it almost impossible to track the patient's progress.

- Managers took part in clinical audits however these were not comprehensive and lacked detail. Clinical audits were recorded in paper files and on the provider's electronic recording system. The paper files did not always reflect the electronic recording system. The paper files contained out of date information. Clinical audits were not comprehensive and lacked detail.
- Managers had not ensured all staff received specialist or mandatory training for their role. We requested training figures from the provider. We found managers inconsistently provided training to all staff regardless of their role. We were particularly concerned around training for bank staff. The training figures the provider sent to us was confusing. The training figures included available Continuous Professional Development modules for each staffing role but not figures for who had completed this training.
- Managers had not ensured nursing staff were trained to communicate effectively with patients. The provider used signalong as an alternative to Makaton. Managers did not provide Makaton or signalong training as mandatory for staff. We requested training figures from the provider. It was unclear from the information the provider sent to us if staff had had signalong training as this was not mandatory.
- Managers had not ensured nursing staff were trained to write easy read care plans. We were told nursing staff write patients easy read care plans and not therapy teams. We reviewed multiple easy read care plans for two patients. We reviewed the same two patient's communication plans. Based on the information present in the patients' communication plans the patients would not be able to understand their easy read care plans.
- At this inspection we found that key risks that we had identified on previous inspection visits had not been fully addressed. For instance, two-way communication was not working in The Lodge seclusion room on our follow up visit. This had been an issue on two previous inspections; November 2018 and December 2017.
- The provider did not learn and carry across information from one scenario to another. We looked at the seclusion rooms in The Lodge and The Grange. We found the temperature gauge was behind a glass panel in The Grange seclusion room and set at 18 degrees. This was not accessible to staff, so they could not respond to patient needs if a patient requested for the temperature to be changed. We found issues around access to the controlled heating in The Lodge seclusion room in November 2018.
- Managers had not ensured patients nursed within long term segregation were nursed in accordance with the Mental Health Act Code of Practice guidelines. We found multiple gaps in two patients 24-hour reviews. These gaps were often over the weekends. The Mental Health Act Code of Practice states that "the patient's situation should be formally reviewed by an approved clinician who may or may not be a doctor at least once in any 24-hour period and at least weekly by the full multidisciplinary team". We found 23 gaps within two patients 24-hour long term segregation reviews of between two and eight days. We found two gaps of two days, six gaps of three days, ten gaps of four days, three gaps of five days, one gap of six days and one gap of eight days. At the last inspection in February 2019 arrangements had not been in place so this was an improvement, however, the provider does still not meet the Mental Health Act Code of Practice guidelines.

Information management

- Staff had access to the equipment and information technology needed to do their work. Staff had access to portable tablet computers where they could input observations and access patient care and treatment plans

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all risks for each ward are identified on the environmental risk assessment.
- The provider must ensure they consider and respond to the environmental and sensory needs of the specialist patient group.
- The provider must ensure they consider and respond to the needs of patients with autism in the ward environment.
- The provider must ensure the design, layout, and furnishings of the ward create a therapeutic environment and is suitable for specific needs of patients.
- The provider must ensure all staff have the required and specialist training for their role.
- The provider must ensure all staff are compliant with safeguarding training.
- The provider must ensure they consistently provide training to staff regardless of their role.
- The provider must ensure they have easy access to all training figures for all staff working at the hospital.
- The provider must ensure staff are trained in Makaton or Signalong to communicate with patients whose main form of communication is Makaton.
- The provider must ensure staff are suitably trained to write easy read care plans.
- The provider must ensure they carry out physical or visual observations of patients after each physical restraint where required.
- The provider must ensure they record an outcome to all physical restraints undertaken.
- The provider must ensure they follow the Mental Capacity Act principles and complete individualised capacity assessments for patients when required.
- The provider must ensure patients' capacity to consent to specific issues are identified and recorded.
- The provider must ensure capacity assessments are updated in line with the Mental Capacity Act.
- The provider must ensure they have effective systems in place to assess and monitor the quality of care for patients.
- The provider must ensure all managers have a good understanding of all aspects of the service they manage.
- The provider must ensure governance meetings are effective in identifying areas for improvement and sufficient priority is set for these meetings to take place regularly.
- The provider must ensure actions set in governance meetings are easily identifiable, have a responsible person allocated to them, and a timeframe allocated to each action.
- The provider must ensure there is sufficient staff on duty, all staff are aware of, and follow their observation policy.
- The provider must ensure they have appropriate assurance systems in place to identify when their policies are not being followed.
- The provider must ensure they follow legal process when implementing a 'Do Not Attempt Resuscitation' form and carry out a decision specific capacity assessment and best interest meeting.
- The provider must ensure all audits are effective, comprehensive, robust, and contain the necessary detail to appropriately oversee the service and make changes where required.
- The provider must ensure that monthly care plan audits are effective in evaluating the effectiveness of the support plan, look at the detail, accuracy and quality of the care plan and can be used to track patient progress.
- The provider must ensure all audit folders contain up to date information.
- The provider must ensure where clinical information is recorded in multiple places, the information is consistent.
- The provider must keep accurate records and appropriately and proactively carry out discharge planning for patients in line with the Mental Health Act Code of Practice.
- The provider must ensure all patients have discharge care plans and clear discharge pathways from the point of the patient's admission.

Outstanding practice and areas for improvement

- The provider must ensure they have appropriate assurances and systems in place for staff checking the emergency bag and the correct equipment being in place at all times.
- The provider must ensure a specific emergency equipment bag checklist is in place.
- The provider must ensure they follow national guidelines and best practice when administering and recording medicines administration.
- The provider must ensure all clinic rooms have ligature cutters and contingency plans in place for emergencies.
- The provider must ensure all clinic rooms have cleaning records.
- The provider must ensure all clinic rooms have clinic room audits.
- The provider must ensure they dispose of sharps appropriately.
- The provider must ensure when recording fridge temperatures in clinic rooms that all actions taken to responding issues are recorded.
- The provider must ensure they address and rectify issues identified previously by the Care Quality Commission.
- The provider must ensure two-way communication is working at all times in seclusion rooms.
- The provider must ensure seclusion rooms have assessible temperature gauges to nursing staff.
- The provider must ensure they follow the Mental Health Act Code of Practice guidelines when nursing patients in long-term segregation.
- The provider must ensure all long-term segregation environments are suitable and meet patient needs.
- The provider must ensure they are responsive to patient needs in relation to supplying personal medical equipment, such as glasses.
- The provider must ensure patients are involved in writing their care plans and have a copy of their care plan.
- The provider must ensure all patient care plans are accurate, consistent and clearly documented.
- The provider must ensure that patients have accessible care plans and can understand their easy read care plans.

Action the provider SHOULD take to improve

- The provider should ensure all information displayed in the service is suitable for patient needs.
- The provider should ensure patient activities are available seven days a week and are person centred and meaningful for each patient.
- The provider should ensure signs and symbols are readily available around the wards or on display to assist patients whose main form of communication is pictorial exchange communication.
- The provider should ensure all patients who require a positive behaviour support plan have one in place.
- The provider should ensure they respond in a timely manner to external stakeholders.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured they considered and responded to the environmental and sensory needs of the specialist patient group. The provider had not ensured staff were able to communicate effectively with a patient who uses forms of communication such as Makaton and Signalong. The provider had not ensured all patient care plans were accurate, consistent and clearly documented. The provider had not ensured patients had accessible care plans and could understand their easy read care plans. This was a breach of regulation 9 (3)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had not ensured they follow the Mental Capacity Act principles and complete individualised capacity assessments for patients when required. The provider had not ensured patients' capacity to consent to specific issues are identified and recorded. The provider had not ensured capacity assessments were updated in line with the Mental Capacity Act. This was a breach of regulation 11 (3)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured all risks were identified on the environmental risk assessment on one of the wards. The provider had not ensured they follow national guidelines and best practice when administering and recording medicines administration. The provider had not ensured staff consistently completed physical or visual observations for patients following physical restraint. The provider had not ensured staff record an outcome to all physical restraints undertaken. This was a breach of regulation 12 (2)(a)(c)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured they followed legal process when implementing a 'Do Not Attempt Resuscitation' form or carried out a decision specific capacity assessment or best interest meeting. This was a breach of regulation 13 (2)(4)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured the service had considered and responded to the needs of patients with autism in the ward environment. The provider had not ensured the design, layout, and furnishings of the ward created a therapeutic environment and was suitable for specific needs of patients.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 15 (1)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured all staff were compliant with safeguarding adults training. The provider had not ensured all staff had the required and specialist training for their role. The provider had not ensured staff were trained in Makaton or Signalong to communicate with patients whose main form of communication was Makaton. The provider had not ensured they consistently provided training to staff regardless of their role. The provider had not ensured they had easy access to all training figures for all staff working at the hospital. The provider had not ensured staff were suitably trained to write easy read care plans. This was a breach of regulation 18 (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured they had effective systems in place to assess and monitor the quality of care for patients. The provider had not ensured they kept accurate records and appropriately and proactively carried out discharge planning for patients in line with the Mental Health Act Code of Practice. The provider had not ensured all patients had discharge care plans and clear discharge pathways. The provider had not ensured they were responsive to patient needs in relation to supplying personal medical equipment, such as glasses. The provider had not ensured all managers had a good understanding of all aspects of the service they managed. The provider had not ensured all audits were effective, comprehensive, robust, and contained the necessary detail to appropriately oversee the service to be able to make changes where required. The provider had not ensured all audit folders contained up to date information. The provider had not ensured that where clinical information was recorded in multiple places, the information was consistent. The provider had not ensured they had appropriate assurances and systems in place for staff checking the emergency bag and the correct equipment being in place at all times. The provider had not ensured a specific emergency equipment bag checklist was in place.

This section is primarily information for the provider

Enforcement actions

The provider had not ensured that monthly care plan audits were effective in evaluating the effectiveness of the support plan, looked at the detail, accuracy and quality of the care plan and could be used to track patient progress.

The provider had not ensured governance meetings were effective in identifying areas for improvement and sufficient priority was set for those meetings to take place regularly.

The provider had not ensured actions set in governance meetings were easily identifiable, had a responsible person allocated to it, and a timeframe allocated to each action.

The provider had not ensured there was sufficient staff on duty, all staff were aware of, and followed their observation policy.

The provider had not ensured they had appropriate assurance systems in place to identify when their policies were not followed.

The provider had not ensured they followed legal process when implementing a 'Do Not Attempt Resuscitation' form or carried out a decision specific capacity assessment and best interest meeting.

The provider had not ensured they addressed and rectified issues identified previously by the Care Quality Commission.

The provider had not ensured two-way communication was working at all times in seclusion rooms.

The provider had not ensured seclusion rooms had accessible temperature gauges to nursing staff.

The provider had not ensured they followed the Mental Health Act Code of Practice guidelines when nursing patients in long-term segregation.

The provider had not ensured all long-term segregation environments were suitable to meet patient needs.

This was a breach of regulation 17 (1)(2)(a)(b)