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	Inadequate
Are services safe?	Requires improvement
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
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

I am placing the service into special measures.

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

We found that the service was not well led at ward level and there was a lack of resource at all levels of leadership. The governance processes did not operate effectively at ward level meaning that performance and risk were not managed well. Clinical and internal audit processes did not have a positive impact on quality governance. The hospital was not adequately staffed. Nearly 90% of the establishment ward staff posts were unqualified support workers and 40% of posts for both nurses and support workers were vacant. The hospital relied heavily on agency staff that covered a high number of shifts. Some of the agency staff were new to the hospital and did not know the patients well. Managers did not provide staff with the induction, training, supervision or appraisal that would have mitigated the staff's lack of qualifications and specialist skills required to provide high quality care to people with such complex needs.

Professor Ted Baker

Chief Inspector of Hospitals

Overall summary

We rated The Woodhouse Independent Hospital as **inadequate** because:

- The hospital was not adequately staffed. Nearly 90% of the establishment ward staff posts were unqualified support workers and 40% of posts for both nurses and support workers were vacant. As a result, unqualified agency staff covered a high number of shifts. This included most of the night shifts. Some of the agency staff were new to the hospital and did not know the patients. This meant that the care plans and positive behaviour support plans developed by the specialist staff were not always enacted by the ward-based staff – some of whom told us that they had not read the plans. Also, the staffing situation meant that a qualified nurse was not always present in communal areas of the ward, that staff were often unable to take rest breaks or regular breaks from enhanced observations, that escorted leave was often cancelled for patients on general observations and that patients did not have regular one-to-one time with their named nurse.
- Managers did not provide staff with the induction, training, supervision or appraisal that would have mitigated the staff's lack of qualifications and specialist skills required to provide high quality care to people with such complex needs.
- The service was not well led at ward level and there was a lack of resource at all levels of leadership. The governance processes did not operate effectively at ward level meaning that performance and risk were not managed well. Clinical and internal audit processes did not have a positive impact on quality governance. There was no structured induction programme for agency staff. Staff were not supported through appraisals and regular supervision to enable

Summary of findings

them to carry out the duties they were employed to perform. There were no regular team meetings for staff to discuss clinical concerns and learning as a team with managers.

- Staff did not always follow systems and processes to safely store and manage medicines. Learning from incidents was not discussed with staff. Managers did not always debrief and support staff after serious incidents.
- The ligature risk assessments lacked clear actions on how the risk was managed. There was no emergency drug (Adrenaline) available to treat anaphylaxis. The checks were not always reliable and valid.
- Staff did not monitor the physical health of patients consistently. Care plans did not always reflect the assessed needs of patients. They were not always personalised, holistic and recovery-oriented nor always updated in a timely manner. Staff did not participate in clinical audits, benchmarking and quality improvement initiatives.
- Staff did not always assess and record capacity to consent clearly where patients might have impaired mental capacity. Staff did not know their identified lead for the Mental Capacity Act.
- There was no sensory room within the hospital to meet the needs of patients who would benefit. Quiet areas on some wards were not available to allow patients an opportunity to avoid noise and disruption. Managers did not regularly review the mix of patients on the wards to ensure the environment was comfortable for all patients.
- The provider had not carried out an autism friendly assessment to ensure that the environment was suitable for patients with autism. The service did not ensure that the needs of patients with specific communication needs were met.

However:

- Staff understood how to safeguard patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with learning disabilities).
- We observed staff treating patients with compassion and kindness. They respected patients' privacy and dignity. The multidisciplinary team involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.
- Staff planned and managed discharge well. Staff helped patients with advocacy, cultural and spiritual support.

Summary of findings

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The WoodHouse Independent Hospital

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Summary of this inspection

Background to The WoodHouse Independent Hospital

The Woodhouse is an independent mental health hospital provided by Elysium Healthcare (Acorn Care) Limited. It was provided by Lighthouse Healthcare until it was acquired by Elysium Healthcare Limited in June 2017. The Woodhouse provides a care pathway of learning disabilities and autism services in a range of small, bespoke units and cottages. The service specialises in providing care for individuals with autism, forensic histories, including sexual offending, highly complex and behaviours that challenge. The service is commissioned by clinical commissioning groups. It provides care for up to 39 male patients under 65 years old who have learning disabilities or autism. The hospital is able to accept patients detained under the Mental Health Act, including Restriction Orders and those supported by Deprivation of Liberty Safeguards.

The Woodhouse hospital has eight units/wards located on a rural site in Cheadle, Staffordshire.

They are:

- Hawksmoor, eight beds, locked rehabilitation/ assessment and treatment ward going under refurbishment into self-contained flats;
- Lockwood, eight beds, rehabilitation ward;
- Farm Cottage, three beds, rehabilitation house;
- Woodhouse Cottage, three beds, rehabilitation house;
- Moneystone, eight beds, autism complex/challenging behaviour ward;
- Whiston, four beds, autism complex/challenging behaviour self-contained flats;
- Highcroft, four beds, autism rehabilitation ward;
- Kingsley, four beds, autism complex/challenging behaviour self-contained flats.

The Woodhouse is registered to provide the following regulated activities:

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

The hospital had a registered manager.

We last carried out a comprehensive inspection for this hospital in January 2017, we rated it as good overall. We rated safe as requires improvement and effective, responsive, caring and well-led as good. We issued the hospital with three requirement notices and these related to:

Regulation 12 HSCA (RA) Regulations 2014, Safe Care and Treatment

- When staff gave oral medication for the purposes of rapid tranquillisation, they did not consistently complete the necessary physical observations.
- There were gaps in checks of the emergency bag on Moneystone and Highcroft wards, and there were no records confirming the cleaning of portable equipment on Moneystone and Highcroft wards.
- The hospital did not have an active clinical lead role (for example, a named nurse) allocated to infection prevention and control.

Regulation 17 HSCA (RA) Regulations 2014, Good Governance

- There were inconsistencies in the completion of forms used for recording observations of the patient in long-term segregation.

Regulation 18 HSCA (RA) Regulations 2014, Staffing

- There were short periods when there was no qualified nurse present on Moneystone ward.
- On Moneystone ward, there were occasions when there were not enough staff to meet patients' individual observation requirements adequately.

There was a follow up inspection carried out in November 2017 to find out whether the hospital had made improvements required since our inspection in January 2017. We found that improvements had been made and we changed the rating of safe to good.

Our inspection team

Team leader: Raphael Chichera

Summary of this inspection

The team that inspected the service comprised four CQC inspectors and a variety of specialists: one consultant psychiatrist in learning disabilities, one nurse specialist in learning disabilities, one speech and language therapist in learning disabilities and one expert by experience.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. We brought forward this inspection after we had received a number of concerns about this service from staff, our Mental Health Act Reviewer, commissioners and families.

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 and asked a range of other organisations for information. This was an unannounced inspection.

During the inspection visit, the inspection team:

- visited all eight units at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with eight patients who were using the service;
- spoke with nine carers/family of patients who were using the service;
- spoke with the registered manager, nurse manager and the regional lead nurse;
- spoke with 46 other staff members; including doctors, nurses, occupational therapist, psychologist, speech and language therapist, domestics, mental health act administrator and hotel services manager;
- spoke with one commissioner and attended one care and treatment review;
- spoke with an independent advocate;
- attended and observed two multi-disciplinary team meetings;
- Looked at 22 care and treatment records of patients;
- looked at 26 prescription cards;
- carried out a specific check of the medication management on all units; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Patients told us staff were kind and treated them with respect and dignity. They involved them in decisions about their care and treatment. Patients felt safe and could raise their concerns with staff.

Patients told us that they had access to a GP anytime and specialists for their physical health problems.

Patients told us that the hospital made frequent use of agency staff who were not familiar with the wards. They also reported that there were not have enough staff on duty at all time; and particularly weekends. Families and carers told us that they had not been provided with the opportunity to give feedback on 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:

- The hospital was not adequately staffed. Forty percent of posts for nurses and support workers were vacant. As a result, agency staff covered a high number of shifts. This included most of the night shifts. Three wards ran entirely on agency staff. Some of the agency staff were new to the hospital and did not know the patients. This was something that patients were concerned about. Those agency staff that had worked shifts at the hospital for some time were moved to work on different wards each shift. This adversely affected continuity of care. The way that staffing was managed meant that a qualified nurse was not always present in communal areas of the ward, that staff were often unable to take rest breaks or regular breaks from enhanced observations, that escorted leave was often cancelled for patients on general observations and that patients did not have regular one-to-one time with their named nurse.
- The service had not done all it could to minimise the use of physical restraint. Although the positive behaviour support plans described actions that staff could take before resorting to restraint, some staff told us that they had not read the plans and other staff were new to the wards and did not know the patients. Also, only senior managers understood and participated in the provider's restrictive interventions reduction programme. They had not promoted awareness of the programme among ward staff to ensure that they understood the meaning of restrictive practice, its impact and how to minimise the use of restrictive interventions.
- Staff did not always mitigate the risks to patient safety posed by the ward environment. The ligature risk assessments lacked clear actions on how the risk identified was to be managed. Lockwood ward had no ligature risk assessment available. Mangers did not share copies of the ligature risk assessments with staff.
- Staff did not always follow systems and processes to safely store and manage medicines. Also, the resuscitation emergency bags to treat anaphylaxis did not contain the drug (Adrenaline) routinely used in the hospital to treat the potential adverse reaction to injectable medicines. The checks to monitor the emergency bags were not always reliable and valid.

Summary of this inspection

- Managers did not discuss learning derived for the investigation of incidents with staff. Managers and staff were not aware of the Learning from Deaths Mortality Review (LeDeR) Programme. Managers did not always offer staff debrief and support after serious incidents.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- All of the provider's own staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with learning disabilities).
- However:
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- All of the provider's own staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with learning disabilities).

Are services effective?

Inadequate

We rated effective as **inadequate** because:

- A high proportion of staff working on the wards lacked the skills, training and experience to support the complex needs of, and provide high quality care to, patients with learning disabilities or autism. A high proportion of ward staff were agency staff and managers had not provided them with the induction, training or clinical supervision that would mitigate their lack of professional training. Also, they had not provided training or leadership development opportunities to ward managers.
- As a result of the staffing situation, ward staff were not always aware of or following the care plans developed by the specialist staff.

Summary of this inspection

- Staff did not have time to fully familiarise themselves with care plans and positive behaviour support plans on wards to use the information in practice.
- Managers did not ensure that staff attended regular team meetings on wards.
- Staff did not consistently monitor physical health. Records reviewed showed that 35% of patients had no hospital passport in place or it was not fully completed with the important information required.
- Care plans did not always reflect the assessed needs and were not always personalised, holistic and recovery-oriented and at times not updated in a timely manner.
- Staff did not participate in clinical audits, benchmarking and quality improvement initiatives.
- Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision where they might have impaired mental capacity.
- Staff did not know their identified lead for the Mental Capacity Act and were not sure where to get advice on Mental Capacity Act.

However:

- The specialist staff developed care plans that were appropriate for the patient group and consistent with national guidance on best practice. However, many of the front-line staff did not have the skills to enact these plans.
- Staff assessed the physical and mental health of all patients on admission, ensured that patients with known problems had access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes.
- The service had good working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- Agency staff who were not familiar with the patients did not have the knowledge or skills to use appropriate communication

Summary of this inspection

methods to support patients to understand and manage their own care, treatment or condition. This included finding effective ways to communicate with patients with communication difficulties.
- Although regular staff understood and supported the individual needs of patients, a significant proportion of ward staff were unfamiliar with the patients and their care plans and therefore could not support patients effectively to meet their needs.
- Families and carers were not provided with information or signposted on how to access carer's assessment.

However:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity.
- The multidisciplinary team involved patients in care planning discussions and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- The service invited families and carers to attend care planning and multidisciplinary team discussions.

Are services responsive?

Requires improvement 

We rated responsive as **requires improvement** because:

- The provider had not carried out an autism friendly assessment to ensure that the environment was therapeutic for patients with autism. The managers had not considered the possible mix of sensory needs of patients living in the same ward.
- There was no sensory room across the hospital to meet the needs of patients.
- There were no quiet areas on some wards. Staff did not review the patient dynamics adequately and regularly to ensure the environment was comfortable for all patients.
- The service had made suitable adjustments for disabled patients to access all the units except one of the cottages. There were no adjustments made for visitors to access the main reception area.
- The service did not ensure that the needs of patients with specific communication needs were met.
- There was no clear learning from complaints shared with staff. Staff did not receive feedback on the outcome of investigations of complaints.

However:

Summary of this inspection

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Discharge was rarely delayed for other than a clinical reason.
- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- Staff helped patients with advocacy and cultural and spiritual support.
- When patients complained or raised concerns, they received feedback.

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

- The service was not well led at ward level and there was a lack of resources at all leadership levels.
- There was a disconnect between the senior leadership and what was happening at ward level.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not managed well.
- Clinical and internal audit processes did not function well and did not have a positive impact on quality governance.
- There was no active strategy to consistently promote equality and diversity in day to day work.
- Staff did not engage actively in local and national quality improvement activities.

However:

- The hospital director clearly understood most of the areas that required improvement and had come up with an improvement action plan to address these areas. There was lack of enough leaders with knowledge and experience to give adequate support. The hospital director was visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Most staff felt respected, supported and valued. All staff felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of June 2019, 91% of the workforce in this hospital had received training in the Mental Health Act. The provider stated that this training was mandatory for all clinical staff and was renewed yearly.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew their Mental Health Act administrators.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy. Staff were aware of how to access and support patients to engage with the independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Patients we spoke with confirmed that their rights under the Mental Health Act had been explained to them.

Staff ensured that patients on constant observations were able to take Section 17 leave (permission for patients to leave hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. However, those on general observations were not always able to take section 17 leave due to lack of staff. Staff made patients and their carers aware of the conditions of leave and any risks and advised them on what to do in the event of emergency.

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

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

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

The Mental Health Act Administrators completed audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. One patient had a section that lapsed and was discovered that the section was not renewed at the time it required to be renewed. This issue was highlighted as part of an audit and resolved.

Mental Capacity Act and Deprivation of Liberty Safeguards

As of June 2019, 88.3% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The provider stated that this training was mandatory for all clinical staff and was renewed yearly.

Most of the staff had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles.

The training compliance reported during this inspection was higher than 86% reported at the last inspection.

Regular staff understood the organisation’s policy on the Mental Capacity Act 2005. The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it.

Staff were not sure where to get advice from within the hospital regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff did not know their identified lead for the Mental Capacity Act.

Detailed findings from this inspection

In some cases, staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. The practice was not consistent. There were cases when there were good easy read and pictorial information made available and in other cases they were none.

Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision. This practice varied greatly within the service, where it was done there were very good examples of assessments and recording. However, there were a number of incidences where no assessments were carried out or recorded around physical health needs and financial needs. We found cases where it was just recorded lacked capacity without any records to indicate how staff had arrived at that decision.

Where staff assessed and recorded patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. However, where the assessments where not recorded we could not be assured that patient's wishes, feelings, culture and history were considered. The decisions in the best interest of patients and what had been considered were not recorded in those cases.

There were no Deprivations of Liberty Safeguards applications made in the last 12 months prior to inspection.

The service had no arrangements to monitor adherence to the Mental Capacity Act. Staff did not audit the application of the Mental Capacity Act to make any changes to improve where needed.

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	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Requires improvement	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- Staff completed and regularly updated risk assessments of all ward areas and removed or reduced any risks they identified.
- Staff could observe patients in all parts of the wards in Moneystone and Whiston only. All other wards had blind spots. However, there were mirrors to mitigate any risks.
- The wards were all male and complied with guidance on same sex accommodation.
- There were ligature risks on all wards within this service. The ligature risk assessments lacked clear actions on how the risk identified from potential ligature anchor points was to be managed.
- Patients had been moved onto Lockwood ward without the ligature risk assessment having been completed after its refurbishment. Staff on the wards did not have copies of the ligature risk assessments shared with them. However, staff mitigated any risks through individual patient risk assessments and close observations.
- Staff had easy access to alarms and radios, but the wards had no built-in nurse call system. Staff individually assessed patients to see the ones that required a nurse call system and were provided with one if needed.

Maintenance, cleanliness and infection control

- All wards were clean and well furnished. However, Hawksmoor and Moneystone's décor and fittings looked worn out. All other wards were well maintained.
- Staff made sure cleaning records were up to date and the premises were clean.
- Staff followed infection control policy, including handwashing. The hospital had one of the charge nurse as the identified lead for infection prevention and control.

Clinic room and equipment

- The wards were fully equipped with accessible resuscitation equipment that staff checked regularly. However, the emergency medicine (Adrenaline) was not available on all but one ward. Adrenaline is used to treat anaphylaxis, a possible adverse allergic reaction to medicines and other possible triggering agents found in the hospital. We noted that in Moneystone staff continued to sign that it was available on the checking form when actually it was not available. This meant that the checks made by staff were not a true reflection of what was held in the emergency bag. Adrenaline had expired and removed from the bags and only to be replaced on 20/06/2019 when the inspection team raised this. The only one on site in Lockwood had expired.
- Staff checked, maintained, and cleaned equipment.

Safe staffing

Nursing staff

- The hospital required a staffing establishment of 22.5 whole time equivalent qualified nurses and 188 support workers. There were 9.5 whole time equivalent (42%)

nurse vacancies, and 76 whole time equivalent (40%) support workers vacancies. The vacancy rate had increased since we last inspected the service in January 2017. At that time, the nurse vacancy rate was 30%.

- As a result of the vacancies, 2375 shifts were filled by agency staff in the three-month period from 01 December 2018 to 28 February 2019. There were 153 shifts covered by bank staff in the same period. A total of 77 shifts had not been filled by bank or agency staff. The main reason for use of agency staff was vacancies.
- Most of the night shifts were covered by agency staff. We visited the night shift on 19 June 2019 and found that only seven staff out of 40 (18%) staff on duty that night were permanent, and the other 33 (82%) were agency. Three wards ran entirely on agency staff. Some of the agency staff had worked regularly on the wards and had some experience of the hospital and familiarity with the patients. Four of the staff were new to the wards and others had only started working for the hospital within a week of our visit. We found that these new agency staff did not know the patients very well. Patients told us there were always new agency staff that were not familiar with the wards. This lack of consistency impacted on the quality of care received by patients. For example, a nurse on her second shift at the hospital was asked to attend a care treatment review meeting on 19 June 2019 for a patient that she didn't know.
- Some agency staff had worked at the hospital long enough to be familiar with the patients and systems. However, they were not used in a way that would put that advantage to effect in developing therapeutic relationships and building effective ward-based staff teams. We looked at the staff rotas for the last three months prior to inspection and found that regular agency staff were consistently moved around the wards on a daily basis. Agency staff told us they were always moved to work in different wards each time they were on duty. This meant there was no consistency and continuity of care and patients did not have familiar staff all the time. This had an impact on quality of care provided to patients, for example, we found that care plans were not always followed.
- Managers did not accurately calculate and review the number and grade of nurses and support workers for each shift to support the needs of both patients and staff. The managers told us they did not use any tool to calculate their staffing levels. Staff reported that they were not able to take rest breaks at work or regular breaks from enhanced observations. Staffing levels in Moneystone, Whiston, Kingsley, Hawksmoor, Lockwood and Highcroft were not enough to give staff regular breaks from observations as the amount of enhanced observations required exceeded the number of staff assigned to the shift if all required breaks were given.
- The staffing situation had an adverse impact on patient care. The qualified nurses spent most of their time in the office dealing with paperwork and on some occasions covering two wards. Highcroft at times shared a nurse with Kingsley and Lockwood shared a nurse with the two cottages. This meant that a qualified nurse was not always present in communal areas of the ward. Staff and patients confirmed this. Patients and staff told us that the wards were very busy and there were not enough permanent nurses to have regular one-to-one meetings with their patients. Also, there were difficulties in facilitating escorted leave for those patients on general observations as there were no staff available to support leave. This was not a problem for patients on enhanced observations.
- There was a lack of leadership at ward level. The wards did not have enough charge nurses to take leadership at ward level to supervise and support the support workers to carry out their roles effectively. For example, some documents were not always completed, and team meetings for nurses and support workers were not happening. There was one nurse manager responsible for managing all wards. We were told two senior nurse managers, who would take up these responsibilities, were on induction at the time our inspection and were due to start the following week. The service had a hospital director and a nurse manager. A lead nurse and another nurse manager that were due to start work after the inspection. They were in the process of recruiting more charge nurses for each ward to be in charge of the wards and running shifts. We were told that where shifts could not be filled as a result of sickness and absence the managers would step in to cover the shifts. The service had high turnover rates. The staff turnover rate at the same period was 42.4%. The managers told us that the turnover rate increased when the culture of the hospital changed with new management taking a new approach to leadership of changes in working pattern, less restrictive practice and more empowering to patients.
- Levels of sickness were low. The sickness rate in the 12-month period from June 2018 to May 2019 was 2.5%.

Medical staff

- The service had enough daytime and night time medical cover and a doctor available to go to award quickly in an emergency. There was a doctor on site weekdays 9am to 5pm. The hospital had an out-of-hours doctor on call system that ensured a doctor could get on site quickly if needed.
- Managers could call on locum doctors when they needed additional medical cover. There was one full time doctor and one locum doctor working three days whole time equivalent over five days to cover a vacancy. Managers made sure all locum doctors had a full induction and understood the service before starting.
- Staff had completed and kept up to date with their mandatory training. The compliance for mandatory and statutory training courses at June 2019 was 94%. The mandatory training programme was comprehensive, and managers monitored it and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We looked at 22 care records of patients and found that each of these contained a risk assessment. Staff completed a risk assessment for each patient when they were admitted and reviewed this regularly, including after any incident. All risk assessments were up to date with changes shown when risk changed.
- Staff used a recognised risk assessment tool. They used different, but relevant, tools depending on the needs of the patient.

Management of patient risk

- Regular staff knew about any risks to each patient and acted to prevent or reduce risks. Each patient had a detailed positive behaviour support plan that clearly showed a good understanding of why the behaviours happened and considered the person as a whole in determining ways to safely support patients.
- Staff identified and responded to any changes in risks to, or posed by, patients. Regular staff were aware of patients' presentation such as early warning signs, triggers and ways of intervening that included teaching new skills.
- Although staff maintained enhanced observations as clinically agreed to keep patients safe and followed procedures to minimise risks. Staffing levels on all wards were not sufficient for staff to get regular breaks from observations, with the amount of enhanced observations exceeding the number of staff available if breaks were considered. This meant that the provider did not follow National Institute for Health and Care Excellence guidance (NG10) by ensuring that each individual staff member did not undertake a continuous period of observation above the general level for longer than two hours. If observations were required for longer than two hours, the provider did not ensure the staff members had regular breaks. For example, in Moneystone, there were six patients in total, four were on 2:1 (requiring eight staff members) and two on 15 minutes intermittent observations (requiring one member of staff) and there were 10 staff on duty. That meant there was only one member of staff free from observations at any given time and staff had to move directly from one set of close observations to another without a break to maintain the safety of patients. The provider's observation policy was not in line with national guidance.
- The practice on observations varied. Most observations on patients were carried out in a therapeutic way particularly where staff knew the patients well. In other cases, we observed that staff were not familiar with patients and it was more custodial, and staff did not interact or tried to engage with patients. The multidisciplinary team regularly reviewed the observations to ensure that this was proportionate to the risk posed.
- The service did not have blanket restrictions approach to care and treatment. Staff individually risk assessed patients according to their level of ability and risk posed.
- Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff recorded the reasons for carrying out a search ensuring that the decision and method used to search was proportionate to the risks. Staff rarely conducted searches on patients and were only carried out where the risk was deemed high.

Use of restrictive interventions

- There had been no instances of seclusion over the last 12 months up to June 2019. No wards used seclusion, they reported that they would not admit any patient that would require seclusion.

- There had been no instances of long-term segregation over the last 12-month period up to June 2019. They reported that they do not practise segregation but would find a better way of managing the patient.
- There was one incident of prone restraint over the six months from 18 December 2018 to 18 June 2019. During that same period, there were 882 incidents of restraint. They recorded any contact with patient as restraint and classed in different ways. They reported 320 restraints as face up and 81 in seated position. The rest accounted for standing and directing patients away. There had been no instances of mechanical restraint over the reporting period. The manager told us mechanical restraint was not allowed in their service.
- Staff reported the use of restraint through the incident reporting system. They told us that the multi-disciplinary team reviewed all incidents of restraint and that most were for self-harming behaviour.
- We concluded that the service had not done all it could to minimise the use of restraint and two patients reported that at times the restraints were forceful and excessive. Although the positive behaviour support plans described different proactive methods that could be used by staff before any restrictive methods such as restraint could be used, some staff told us that they had not read the plans and other staff were new to the wards and did not know the patients. Also, only senior managers understood and participated in the provider's restrictive interventions reduction programme. Although there was a strong drive on reducing restrictive practices which had been successful in ending the use of seclusion, avoiding long-term segregation, and no blanket restrictions, there was no restrictive practice awareness campaign to support staff in understanding the meaning of restrictive practice and its impact. There was no effective leadership on the wards to lead on the programme and therefore the reducing restrictive practice strategy was not shared with staff in a forum where staff could participate.
- The provider trained staff in physical interventions and ensured that all agency staff had the same training and they were aware of the techniques required.
- There had been no incidents of rapid tranquilisation over the reporting period. The service understood rapid tranquilisation as the use of medication by the intramuscular route as stated in NICE (NG10). When required (prn) oral medication was used as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression. It was not used often.

Safeguarding

- 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.
- Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.
- This hospital made 64 safeguarding referrals between July 2018 and June 2019.
- The hospital had no serious case reviews commenced or published in the last 12 months from July 2018 to June 2019.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There was an incident where staff reported inappropriate use of restraint by other staff and the managers took appropriate action against the staff members involved.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns.
- Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff knew how to identify adults and children at risk of, or suffering, significant harm.
- Staff followed the hospital's policy for children visiting the wards to ensure safety. Staff discussed, and risk assessed visits from children considering any child protection issues. There where meeting rooms away from the wards where visiting children could meet with patients safely.

Inadequate

Wards for people with learning disabilities or autism

Staff access to essential information

- Staff used electronic patient records and they kept detailed records of patients' care and treatment.
- Records were clear, up-to-date and easily available to all staff providing care including some of the regular agency staff but not all agency staff. It was also accessible to all relevant staff when patients moved between wards.
- Staff used paper records for observations and prescription charts and this did not cause any difficulties in entering or accessing information. The wards had paper records with overview of patients' information on the wards meant to be given to new agency staff.
- Records were stored securely.

Medicines management

- Staff did not follow the correct process for recording and storing of medicines consistently. Staff left gaps in the signing of medicines charts on all wards, it was highest on Moneystone ward, and failed to indicate whether medicines had been taken, omitted or refused. Staff did not date medicines such as creams and liquid in bottles that required dating when they were opened. This would have ensured that the effectiveness of the medicine could be monitored. The issues were picked up in the provider's medicines audits, but no action was taken.
- Staff did not write down the dates that glucagon hypoglycaemia kit was first stored in the emergency bag outside the refrigerator. There was no evidence of the new expiry date as this medicine could only be kept for 18 months outside the refrigerator for it to be still effective when given to patients. They relied on the expiry date of the medicine from the manufacturer which dependent on the medicine always being stored in the fridge.
- There were no door signs on all wards to show the rooms where oxygen cylinders were kept. This did not assure that all staff and patients would be aware of all safety precautions to be taken where oxygen was stored.
- Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients were given easy read information on possible drug interactions, minimum effective doses, contra-indications and side effects. Staff monitored and reviewed the effectiveness of the medicines prescribed.
- Staff followed current national practice to check patients had the correct medicines. They worked closely with a local pharmacy that provided support and advice to the hospital.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
- Decision making processes were in place to ensure patients' behaviour was not controlled by excessive and inappropriate use of medicines. Staff knew about and worked towards achieving the aims of STOMP (Stop Over-Medicating People with learning disabilities). Most of the patients were on very low doses of medicines, no more than two antipsychotic medicines and others were medicine free.
- Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence guidance. Health checks were carried as required for those patients on antipsychotic medicines.

Track record on safety

- The service had a good track record on safety. Between July 2018 and June 2019 there were two serious incidents reported by this service. Of the total number of incidents reported, one was of a fall resulting in a dislocated hip and the other one was of an unexpected patient death. The fall was unobserved, and the death was certified by the coroner as natural death.
- A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.
- The number of serious incidents reported during this inspection was higher than one reported at the last inspection.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to report them. However, not all agency staff had access to the incident reporting system they had to ask those staff with access to report incidents.

Inadequate

Wards for people with learning disabilities or autism

- Staff reported all incidents that should be reported. Staff recognised incidents and reported them appropriately. We found that some of the incidents reported had not been linked through the system to patients' notes after the incident had been reviewed. This was later resolved after realising that it was the whole organisation's information technology problem.
- Staff reported serious incidents clearly and in line with provider policy.
- The service had no never events on any wards.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.
- Managers did not always debrief and support staff after serious incidents. Staff told us they did not always get debrief and support after serious incidents, occasionally psychology department offered debrief support, but it was not consistent.
- Managers investigated incidents thoroughly. Patients and their families were not always involved in these investigations.
- Staff did not receive feedback from investigation of incidents, both internal and external to the service. Staff told us they were not aware of any feedback from investigations of incidents. The feedback was shared among the senior managers and nurses that attended the morning meetings where incidents were discussed. Due to lack of leadership on the wards the feedback was not shared with all staff on the wards.
- There was no formal or structured way where staff met to discuss the feedback and look at improvements to patient care. The manager circulated a hospital bulletin with lessons learnt each month. However, staff told us they were not aware of the lessons learnt as this was not embedded yet.
- There was evidence that changes had been made as a result of feedback. Staff were not able to tell us changes that had been made as a result of feedback. However, the managers gave a number of examples where practice had changed as a result of learning from incidents, for example, improvements to handover system, a process for storing and archiving written documentation and training for buccal midazolam for all agency nurses.
- Managers and staff were not aware of the Learning from Deaths Mortality Review (LeDeR) Programme. Managers and staff had not learnt anything from the review process and were not aware of any learning it recommended.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- Staff completed a comprehensive mental health assessment of each patient either on admission or before admission. We looked at 22 patients' care records that showed that staff assessed the mental health needs of all patients in a timely way and identified all patients' needs.
- Staff assessed patients' physical health needs in a timely manner soon after admission. Staff ensured that all patients had a physical examination within 24 hours of admission and recorded any physical health problems. However, physical health was not monitored consistently, records seen from the live dashboard showed that only 60% of patients had an up to date annual physical health check. The records received later from the hospital from their GP showed that all patients had an up to date physical health check. Patients with constipation had no care plans in place and bowel monitoring charts were not always completed. The National Early Warning Score were not consistently completed where care plans required patients to have these completed as part of their physical health monitoring plan.
- Although some patients had an up to date hospital passport, 35% of patients had either no hospital passport in place or it was not fully completed with all required meaningful details. A hospital passport is a document for people with learning disabilities that contain their health needs and other useful information, such as your interests, likes, dislikes and preferred method of communication to help hospital staff make them feel more comfortable when admitted into hospital.

- The care plans developed by staff varied in their quality. There were cases were staff developed care plans that addressed the needs identified during assessment. These care plans contained clear details of what they aimed to achieve and how each identified need was to be met. However, other care plans lacked detail of how important physical healthcare needs, and associated risks, would be addressed and managed – including epilepsy and diabetes.
- Staff regularly reviewed the care plans but sometimes delayed updating care plans and positive behaviour support plans when patients' needs changed.
- There was inconsistency in the degree of personalisation of care plans. Although some care plans were personalised, holistic and recovery-orientated. There were areas where care plans were not person centred, they did not have clear goals and represent the patients' views, contained the same information for different patients and lacked detail about individual needs.
- The hospital had just introduced new positive behaviour support plans that incorporated the reinforce appropriate, implode disruptive (RAID) approach. This is a positive psychology least restrictive approach for working with people that present with behaviour that challenge. Positive behaviour support plans were present for all patients and were supported by a comprehensive assessment. The positive behaviour support plans were psychology led, person centred and informed by a functional assessment carried out to help understand the reasons behind the behaviour that challenged.

Best practice in treatment and care

- We looked at 22 patients care records and medicine prescriptions. The medication and psychological therapies that were described were in line with National Institute for Health and Care Excellence guidance. These included interventions that would enable patients to acquire independent living and social skills. However, although many patients had care plans that specified the interventions that would address their needs, we concluded that these intentions were often not translated into action. A number of staff told us that they had not read patients' care plans or positive behaviour support plans and we found instances where staff were not following them or not completing monitoring documents as required by the plan. This failure to enact care plans was due to a lack of clear leadership at ward level and insufficient ward staff with the necessary skills, knowledge and familiarity with the patients.
- The hospital had a contract with a local GP that visited the hospital to see patients that were not able to go to the GP surgery. Staff could make referrals to the GP at anytime for any physical health problems. Also, patients had good access to physical healthcare specialists for specific, identified needs. This included close links with neurologists for patients with epilepsy. The hospital had been trying to recruit a registered general nurse to run the physical health clinics.
- Staff assessed those needing specialist care for nutrition and hydration. Referrals to a dietician were made when required. The speech and language therapist carried out some assessments of patients experiencing difficulties with their eating, drinking and swallowing. However, ward staff did not consistently monitor fluid and food intake for patients that had nutritional and hydration needs, and records were not regularly reviewed.
- Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The patients had access to smoking cessation programmes, physical exercises, acting on healthy eating advice. The service offered a wide range of activities to patients. The occupational therapists assessed patients and encouraged them to actively engage in routine meaningful and purposeful structured daily programme of activities. However, patients with sensory needs had no access to a sensory room to support their individual needs.
- Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.
- Staff did not take part in clinical audits, benchmarking and quality improvement initiatives apart from medicines and National Early Warning Score audits. The hospital had an audit programme of different clinical areas to be monitored but was not used. These audits were not detailed on their findings. Managers did not use results or follow up any actions from these two audits to make improvements.

Skilled staff to deliver care

- The service had access to full range of specialists relevant to the needs of the patients on the ward. This included one full time and one part time locum doctor,

nurses, two full time occupational therapists, one full time psychologist, art psychotherapist, one full time speech and language therapist, occupational therapist assistants, assistant psychologists, trainee nurse associates and recovery support workers.

- In contrast, many of the staff that worked shifts on the wards lacked the skills or knowledge needed to meet the complex needs of the patients with learning disabilities and autism in their care or to put into effect the care plans developed by the specialist staff. As described above, on many shifts only a small proportion of staff working directly with patients were regular, permanent staff and only a few were qualified nurses. Because a number of agency staff were new to the hospital, and because of the way that the service deployed agency staff who had worked at the hospital before, many staff working on the wards did not know the patients well or what their care plans contained. We spoke to one agency staff member who could not speak English well.
- The managers of the hospital did not provide training that mitigated the lack of knowledge or skills of many of the staff working on the wards. The hospital provided new, permanent staff members with an induction programme but there was no structured induction programme for agency staff that worked on the wards. Agency staff told us that they just had verbal induction on the first day on duty but no written induction or further induction of the environment and patients when moved to other wards. This was a particular problem for new agency staff that worked on wards that were fully staffed by other agency workers.
- Although permanent recovery support workers had access to training equivalent to care standards certificate, agency staff told us they received no training from the provider and had not received training in learning disabilities, autism and positive behaviour support. Agency staff who worked regularly at the hospital received only basic mandatory training.
- Managers had not identified the training needs of their staff or given them the time and opportunity to develop their skills and knowledge. Staff were not trained in patients' specific needs as outlined in recommendations for treatment plans such as picture exchange communication system (PECS) and Makaton. Also, the provider did not ensure that ward staff had received the training to equip them to meet patients' physical health conditions, such as diabetes and epilepsy.
- Managers did not support staff through regular, constructive clinical supervision and appraisal of their work. There was no regular appraisal and supervision available to staff and managers did not have a reliable system to monitor this. Only about one-fifth of nursing had received regular supervision or undergone appraisal. Although managers had started to roll out a plan for implementing appraisal and supervision, most staff we spoke with said they had not received either.
- Managers did not ensure that staff attended regular team meetings. The wards had no staff meetings taking place at all. There were no experienced ward leaders to make this happen. The hospital had a nurse meeting once every month. The psychologist ran reflective practice sessions where they discussed patient clinical information, reflection and support to staff, but these were not attended by many staff.
- The nurses who managed the wards did not have the skills and experience to ensure that the wards functioned effectively. Not every shift was covered by a charge nurse and the charge nurses had not received leadership training. Ward leaders did not effectively support junior staff to follow care and treatment plans for patients on the floor as recommended by the multidisciplinary or therapies team to meet the needs of patients.
- Poor staff performance was dealt with promptly and effectively. The managers had readily available support from human resources department to deal with this.

Multi-disciplinary and inter-agency team work

- Staff held regular multidisciplinary meetings to discuss patients and improve their care. They held in-depth discussions that addressed the identified needs of the patients such as risk, safeguarding issues, physical health issues, medication review, discharge planning and changes to care plans. However, we concluded that elements of these plans were not enacted because the front-line staff did not have the skills necessary to do this.
- Staff shared information about patients and any changes in their care, including during handover meetings. The wards held handovers at the end and

start of each shift and had a comprehensive handover form and the multidisciplinary team held meetings each morning to discuss any safety concerns. However, staff on the wards did not fully complete all information on handover forms.

- Ward teams had good working relationships with other teams in the organisation. They had regular discussions with the therapies team, catering department and the administration team.
- The provider had effective working relationships with external teams and organisations. They had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.

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

- Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.
- As of June 2019, 91% of the bank and substantive workforce in this hospital had received training in the Mental Health Act. The provider stated that this training was mandatory for all clinical staff and was renewed yearly.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew their Mental Health Act administrators.
- The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.
- Patients had easy access to information about independent mental health advocacy. Staff were aware of how to access and support patients to engage with the independent mental health advocacy and patients who lacked capacity were automatically referred to the service.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Patients we spoke with confirmed that their rights under the Mental Health Act had been explained to them.
- Staff ensured that patients who were on constant observation were able to take Section 17 leave (permission for patients to leave hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. This was not always the case for patients on general observations because of the staffing situation. Staff made patients and their carers aware of the conditions of leave and any risks and advised them on what to do in the event of emergency.
- Staff requested an opinion from a Second Opinion Appointed Doctor when they needed to. Consent to treatment and capacity forms were appropriately completed and attached to the medication charts of detained patients.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.
- Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.
- The Mental Health Act Administrators completed audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. One patient had a section that lapsed and was discovered that the section was not renewed at the time it required to be renewed. This issue was highlighted as part of an audit and resolved.

Good practice in applying the Mental Capacity Act

- As of June 2019, 88.3% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The provider stated that this training was mandatory for all clinical staff and was renewed yearly.
- Most of the staff had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles.
- The training compliance reported during this inspection was higher than 86% reported at the last inspection.
- Regular staff understood the organisation's policy on the Mental Capacity Act 2005. The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it.
- Staff were not sure where to get advice from within the hospital regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff did not know their identified lead for the Mental Capacity Act.

Inadequate

Wards for people with learning disabilities or autism

- In some cases, staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. The practice was not consistent. There were cases when there were good easy read and pictorial information made available and in other cases they were none.
- Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision. This practice varied greatly within the service, where it was done there were very good examples of assessments and recording. However, there were a number of incidences where no assessments were carried out or recorded around physical health needs and financial needs. We found cases where it was just recorded lacked capacity without any records to indicate how staff had arrived at that decision.
- Where staff assessed and recorded patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. However, where the assessments where not recorded we could not be assured that patient's wishes, feelings, culture and history were considered. The decisions in the best interest of patients and what had been considered were not recorded in those cases.
- There were no Deprivations of Liberty Safeguards applications made in the last 12 months prior to inspection.
- The number of Deprivations of Liberty Safeguards applications made during this inspection was the same as none reported at the last inspection.
- The service had no arrangements to monitor adherence to the Mental Capacity Act. Staff did not audit the application of the Mental Capacity Act to make any changes to improve where needed.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, provided patients with help, emotional support and advice at the time they needed it. We observed staff interacting with patients in a way that demonstrated respect and a caring nature. Staff supported upset patients in a compassionate and sensitive way. Staff were always available to support patients. Patients that we spoke with told us that staff treated them well and behaved appropriately towards them and spoke positively about their privacy, dignity and wellbeing at the hospital.
- The professional staff and regular ward staff who were familiar with the patients, used appropriate communication methods to support patients to understand and manage their own care treatment or condition. However, a significant proportion of ward staff were not familiar with the patients and did not have this knowledge or these skills. Staff encouraged patients to be independent as far as possible focussing on their strengths. Some patients self-medicated and others understood their early warning signs and triggers. Staff enabled patients to participate in social skills, leisure skills and independent living skills that were tailored to individual needs.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services. All patients were registered with a local GP and dentist, and staff arranged and supported patients to attend appointments when they complain of any physical health problem. However, staff did not always follow care plans to monitor physical health problems, for example completing bowel movement and fluid and dietary intake charts. Carers told us that staff arranged appointments at times that suited patients. For example, if a patient was more likely to have seizures in the morning, they would arrange appointments in the afternoon.
- Regular staff understood and supported the individual needs of patients, including their personal, cultural, social and religious needs. These staff responded to patients differently considering and being sensitive to their individual needs. We saw care plans that detailed how to support patients through Ramadan, with evidence of monitoring nutrition and hydration through food and fluid charts. However, a significant proportion of ward staff were unfamiliar with the patients and their care plans and therefore could not work in this way.

Inadequate

Wards for people with learning disabilities or autism

- Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff gave good examples of what they could report as concerning behaviour towards patients.
- Staff followed policy to keep and maintain patient information confidential.

Involvement in care

- Staff introduced patients to the ward and the services as part of their admission process. Welcome packs were provided to patients and were available in an easy read format.
- The multidisciplinary team involved patients in the ward reviews and care programme approach as much as they could and discussed treatment options with patients. Patients' views were considered during care planning. Staff offered patients as much choice as possible about their care and treatment. Patients had access to copies of their care plans. Patients told us they were encouraged to attend their reviews and were happy with their involvement in their care and treatment.
- Regular staff that knew patients well communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. However, it was not always the case with agency staff that were not familiar with the patients. There was easy read information available to patients about their medicines, Mental Health Act rights and easy read care plans. However, this was not consistent across all wards. Each patient had a communication assessment that gave information on how best to communicate with each patient.
- Patients could give feedback on the service and their treatment and staff supported them to do this. There was a monthly patient community meeting that took place to enable patients to raise any concerns or suggestions to improve the service. The hospital also carried out patient surveys.
- Staff supported patients to make advanced decisions on their care. The service had no patients with advance decisions.
- Staff ensured patients had access to advocacy. The advocate was skilled in working with people with learning disabilities and visited the hospital regularly and attended multidisciplinary team meetings. Patients had the contact details of the advocate and were able to contact them when needed.
- Staff supported, informed and involved families or carers. Carers told us that they were able to obtain information about their relative if they telephoned the service. However, this depended upon whether a member of staff on shift knew the patient. Some carers told us that they had requested to receive a weekly update, but this did not always happen. All carers were able to attend multidisciplinary team review meetings regularly.
- The service had not supported families to give feedback on the service. They had arranged their first carers/ family day to take place on 5 July 2019. Families and carers that we spoke with told us that they had not been provided with the opportunity to give feedback on the service.
- Families and carers were not provided with information or signposted on how to access carer's assessment.

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 between September 2018 and February 2019 was 79%. Lockwood ward was closed for refurbishment from November 2018 to June 2019.
- The provider accepted referrals from all of England. The average length of stay for the service was 42 months, there were three outlier patients on restriction order from the home office and had been at the hospital for over 10 years. The average length of stay was 27 months if those patients were excluded.
- There was always a bed available when patients returned home from leave.

Inadequate

Wards for people with learning disabilities or autism

- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interest of the patient.
- When patients were moved or discharged, this happened at an appropriate time of day. The multidisciplinary team planned and co-ordinated the discharges with other necessary external agencies in a collaborative way well in advance.
- It was rare for any patients to require a psychiatric intensive care bed. If this did occur, the service would continue to care for the patient while a more appropriate bed was being sourced.
- Staff planned for patients discharge, including good liaison with care managers and coordinators. The care programme approach meeting was held to discuss the discharge plan that included the crisis plan. Each patient had a care and treatment review carried out in line with NHS England transforming care programme. Patients visited new placement on trial leave to see how they coped as part of their transition. During our inspection, staff members from a patient's new service were visiting to provide support and getting familiar with the patient's needs.
- The service reported no delayed discharges between January 2018 and February 2019.
- Staff supported patients during referrals and transfers between services. Staff stayed with patients when admitted into acute hospital for physical health problems.
- The service complied with transfer of care standards.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms with en-suite facilities. Whiston and Kingsley wards provided self-contained apartments where patients had their own lounge and kitchen area. Hawksmoor was about to go under refurbishment to provide self-contained flats.
- Patients could personalise their bedrooms. We saw posters, photographs, personal bedding and other personal items in patient bedrooms.
- Patients had somewhere secure to store their possessions. There were lockable facilities in bedrooms which patients had a key for. Some patients had a key to their own bedrooms.
- Staff and patients had access to the full range of rooms and equipment such as clinic rooms, activity and therapy rooms and a family room, to support treatment and care. However, there was no sensory room across the hospital considering the needs of their patient group they could benefit from a sensory room.
- There were no quiet areas on some wards. This was particularly an issue where other patients were quite noisy, and others did not like it. For example, on Moneystone one patient was isolating them self in their bedroom because of the noisy ward environment. On Kingsley, one patient had noise as one of the triggers on their behaviour support plan and the ward was noisy at times with loud music. The patient dynamics w not adequately and regularly reviewed to ensure the environment was comfortable for all patients. We did not see how each patient's individual risk and their social interactions with other patients were considered before placing in a particular ward.
- The ward environment for people with autism was not therapeutic. The provider had not carried out an autism friendly assessment (autism friendly environment checklist) to ensure that reasonable adjustments were made to meet the national guidelines for autism friendly environment National Institute of Health and Care Excellence clinical guideline [CG142]. The managers had also not considered the conflicting sensory needs of patients living in the same ward.
- There were rooms away from the wards where patients could meet visitors.
- Patients could make a phone call in private. Some patients had access to a mobile phone and could speak privately in their bedrooms. This was individually risk assessed. Other patients that did not have a mobile phone, were able to use the ward mobile phone to make and receive calls in private.
- Patients had access to the outside space. Patients on Moneystone and Highcroft ward did not have easy access to outside space as the wards were located upstairs.

- The service offered a variety of good quality food. However, there was no easy read/pictorial menu choice to help patients understand their food choices. Staff told us patients did not easily understand the available written menu choices which often caused problems at meal times. Patient were often confused about their choices when they saw the food being served. This led to patients sometimes refusing meals and saying that was not what they ordered.
- Patients were able to independently make hot drinks and snacks 24/7, dependent upon their individual risk assessment.

Patients' engagement with the wider community

- Staff made sure that patients had access to opportunities for education and work, and supported patients. The occupational therapy team had recently developed a scheme, where patients were employed to carry out different jobs such as car maintenance. One patient had a voluntary job with a local charity group.
- Staff supported patients to maintain contact with their families and carers. Patients were able to visit home on leave and be visited by their relatives. Staff supported patients with phone calls to their relatives.
- Staff encouraged patients to develop and maintain relationships that mattered to them, both within the services and the wider community. Patients were able to get in contact with other professionals outside of the service and list of contact details of those involved in their care were maintained.

Meeting the needs of all people who use the service

- The service had not made enough suitable adjustments for disabled patients or visitors to access the premises. The reception area was located above a flight of stairs with no lift or other disabled access. Moneystone and Highcroft had a lift. There was no disabled access to one of the cottages.
- The service did not always ensure that the needs of patients with specific communication needs were met. We found that some staff working with patients' who had specific communication needs set out in their care and treatment plans' such as picture exchange communication system and Makaton, had no training to meet their needs.
- Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. The information provided was in a form accessible to the patient group. There were easy read versions of documents such as care plans, rights, complaints and compliments. However, we found that these documents were not used available consistently across all wards.
- Staff made information leaflets available in languages spoken by patients.
- Managers ensured that staff and patients had access to interpreters and/or signers when required.
- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.
- Staff ensured that patients had access to appropriate spiritual support. During our inspection, we found that patients were supported through Ramadan and that there was a multi-faith room available to patients.

Listening to and learning from concerns and complaints

- The service received four complaints from March 2018 to February 2019, three of which were upheld, and none were referred to the Ombudsman. The service received 13 compliments within the same period.
- Patients knew how to complain or raise concerns. There were complaints forms available to patients on each ward, with some wards providing easy read versions. Patients could go to staff as the first point on how to raise concerns. They could also raise their complaints through the advocate.
- When patients complained or raised concerns, they received feedback.
- Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff were aware of how to handle complaints appropriately
- Staff knew how to handle complaints appropriately. Staff we spoke to stated that they would pass the complaint onto the nurse in charge or the nursing manager. Staff also said that they would try to resolve more informal complaints at ward level.

- Staff did not receive feedback on the outcome of investigations of complaints and acted on the findings. Staff told us managers did not share with them outcomes from complaints and were not aware of any lessons learnt from complaints.

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

Inadequate

Leadership

- There was a lack of leadership at ward level. The hospital had no ward managers and had only recently introduced the charge nurse posts to manage the wards. There were not enough charge nurses with the right skills, knowledge and experience to perform their roles. The hospital director, nurse manager, psychology lead, occupational lead and the consultant formed the senior leadership team. The leadership resources were not enough to allow them to effectively perform their full roles. The hospital had introduced two more senior leaders to the team, a nurse manager and a lead nurse to support the leadership team. One was on induction during inspection and the other one was due to start in July. There was support from the regional nurse lead three days a week to fill the gap in leadership at the same time as the recruitment was done.
- The hospital director clearly understood most of the areas that required improvement and had come up with an improvement action plan to address these areas. There was lack of enough leaders with knowledge and experience around to give adequate support. They understood their current challenges, risks and how they were trying to mitigate these. They clearly explained how the teams worked and what were the future plans to achieve high quality care and the goals of the service. The hospital director was in post since October 2018 and had been working hard on recruitment and retention strategy.
- The leaders were visible in the service and approachable for patients and staff. However, there was a mixed view from staff, most staff spoke highly of the support they received from the managers. Some told us they did not get enough support from managers, some said they are approachable but do no act on all matters raised.
- The hospital had recently started to run leadership courses for managers and junior staff. The programme was being gradually rolled out as part of their ongoing professional development plan for all staff. It was a programme to develop staff skills to take on more senior roles.

Vision and strategy

- The service had a vision for what it wanted to achieve and a strategy to turn it into action. Most staff knew and understood the vision and values and how they were applied in their everyday work within the team**.** However, most agency staff did not understand the organisation's values. They did not always understand how their role contributed to achieving the strategy. Managers did not make sure that agency staff understood their values and knew how to apply them.
- The provider's senior leadership team had communicated the provider's vision and values to the frontline staff in this service. The leaders knew very well about the future service they wanted to build.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. They reported that they were not involved in all discussions but at times they were asked for ideas about how the service was run. They felt they had not been fully involved in developing the strategy of the service.

Culture

- Most staff felt respected, supported and valued by their managers. However, there was mixed feelings about management support on issues around sickness and when injured at work. From 18 December 2018 to 18 June 2019 the hospital recorded 135 staff injured by assault and 23 by restraint. Some staff felt they did not get adequate psychological support from the management after they had been injured at work. Most of the staff reported feeling positive and proud about working for the organisation apart from a few staff.

- Staff felt able to raise concerns without fear of retribution. The leaders took all concerns seriously, listened to their staff and supported them. Most of the staff said they had seen a change since the new hospital director had been in post.
- Staff knew how to use the whistle-blowing process and about the role of the freedom to speak up guardian. They felt confident to do so when required.
- Managers dealt with poor staff performance when needed. There was support from the human resources team if required.
- The teams did not work well together and where there were difficulties they lacked ward managers to deal with them appropriately. There were no established core teams in each ward that had a leader and effective working relationships. The teams were not cohesive, they were diluted by a lot of agency staff that were not established team members. However, staff were keen to support each other to deliver good quality patient care.
- Managers did not provide staff with appraisals consistently that included conversations about career development and how that could be supported. However, support workers were supported to attend nurse associate training and all staff to attend leadership courses.
- There was no active strategy to consistently promote equality and diversity around protected characteristics in day to day work. Staff were not aware of any promotion ways that provided opportunities for career progression through offering equal opportunities for all. The hospital did not have a champion/lead person or a group that promoted equality and diversity around black and Minority Ethnicity or Lesbian, Gay, Bisexual, and Transgender within the hospital.
- The service reported a staff sickness and absence rate of 2.5% from June 2018 to May 2019.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. Managers could signpost staff to occupational health for well-being support if needed.
- The provider recognised staff success within the service. The hospital had a staff awards system to recognise staff and team achievements.

Governance

- The operational governance processes to manage quality and safety did not operate effectively. Although the service had a good dashboard that collected essential information from all wards, this information was not fully used to monitor the quality and performance of the service.
- There were no clear arrangements on how all key information such as incidents, complaints, safeguarding, staffing, training and audits reported by staff to management was analysed. There was no clear system in place on how the results of any analysed information was feedback to staff and patients on the wards to ensure improvements were made. There was no clear framework of what was discussed at ward or service level and any learning that was shared and discussed.
- Staff were not aware of recommendations implemented from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. However, the managers could give examples of changes made.
- Staff did not undertake or participate in local clinical audits. There were not enough audits to provide assurance that the quality and standards of care were effectively monitored. The area that was monitored had no actions or recommendations taken to address poor practice that had been identified.
- Staff understood the arrangements for working with other teams, both within the organisation and external to meet the needs of the patients. There were good working relationships with some commissioners, acute hospital, local authority, local community, voluntary sector and GP.

Management of risk, issues and performance

- The service had the processes to manage current and future performance. However, the process to identify, understand, monitor and address current and future risks was not linked effectively into the planning process. The managers maintained and had access to the risk register for the service. Staff were not aware of the risk register and it was not shared with them. They could escalate concerns to management when required from a team level.
- Clinical and internal audit processes did not function well and did not have a positive impact on quality governance, with no clear evidence to monitor action taken to resolve concerns.

- The service had plans for emergencies that set out the measures the service would take to ensure safety of patients in the event of an emergency or adverse weather conditions.
- There were no cost improvements in place at the time of inspection. The service was not under pressure to fill the beds. They told us they had rejected about 70% of the referrals in the last six months prior to inspection as they were deemed clinically inappropriate. The sustainable delivery of quality care was not put at risk by the financial challenge.

Information management

- The service used systems to collect data from wards and that were not over-burdensome for frontline staff. Staff reported that methods used to give information to senior management were easy to use.
- All permanent staff had access to the equipment and information technology needed to do their work. Not all agency staff had access to information technology. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The hospital intranet provided staff with easy access to all relevant information such as provider's news, policies and sharing good practice.
- Information governance systems included confidentiality of patient records. There were systems to protect patients' data both electronic and paper based.
- Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. They had access to a live dashboard which covered a wide range of key areas of service performance.
- Information was in an accessible format, and was timely, accurate, and identified areas for improvement.
- Staff made all notifications to external bodies as needed. The Care Quality Commission received relevant notifications as required. The local authority received safeguarding alerts notifications.

Engagement

- Staff and patients had access to up-to-date information about the work of the provider and the services they used. The carers and families told us the communication with the hospital was not very good to keep them well informed about the service. The hospital arranged its first carers and family's day in July to engage with them, seek their views, update them about the service and provide them with any relevant information. The provider had a website with information about the services.
- The provider had ways to keep their staff and patients well informed and up to date about the service. They used intranet, emails, newsletters, noticeboards and face to face meetings.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The service used ways such as suggestion box, surveys, meetings, open discussion, and the advocate on how patients and carers could give feedback to the service.
- The service welcomed feedback from patients, carers and staff and the managers used it to make improvements. There were examples of improvements made because of feedback from patients. Feedback was always reported and acted on in a timely way.
- Patients and carers were not always fully involved in decision-making about changes to the service. Patients and carers were not always consulted about changes in the service.
- Patients and staff could meet with members of the provider's senior leadership team to give feedback. Managers took the feedback from patients seriously.
- Directorate leaders engaged with external stakeholders such as commissioners and local authority.

Learning, continuous improvement and innovation

- Although the provider had a corporate provider compliance assessment team that visited all hospitals to assist with any issues surrounding compliance. Staff were not given the time and support to consider opportunities for improvements and innovation that led to changes. There were no members of staff that were allocated to take the lead in implementing best practice and improvements in key clinical areas. Improvements were not always identified, or action was not always taken.
- Staff did not participate in research.
- Some innovations were taking place in the service. The psychology team reviewed the use of the latest psychological models to work with their complex patient groups. The speech and language therapist won

the National Learning Disabilities Award for "breaking the barriers" for finding creative ways of enhancing communication with patients with communication difficulties.

- Although the organisation had systems to support improvement such as rewards, data systems, and ways of sharing information. Staff did not use quality improvement methods and did not know how to apply them. Staff lacked the knowledge and skills to use improvement methods.
- Staff did not participate in national audits and accreditation schemes relevant to the service and learned from them.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the ligature risk assessments for each ward are detailed enough to address identified risks and shared with staff on the wards.
- The provider must ensure that the checks made by staff on emergency equipment and medicines are reliable and valid as true reflection of what was held in the emergency bag.
- The provider must ensure that all wards have enough nursing staff of all grades to meet the needs of the patients and adequately put systems and processes to mitigate the risks associated with high use of agency.
- The provider must ensure that they accurately calculate and review the number and grade of nurses and support workers for each shift to allow staff to get rest breaks and regular breaks from enhanced observations according to National Institute of Health and Care Excellence guidance.
- The provider must ensure that there is clear leadership at ward level and that staff on duty are always experienced and have the right skills and knowledge to meet the needs of the patient group.
- The provider must ensure that the wards have good staff skill mix and that all staff including agency have received specific training to equip them with the right skills required for working with people with learning disabilities or autism. Staff must receive the necessary specialist training for their roles.
- The provider must ensure that there is a comprehensive structured induction programme for agency staff to all the wards.
- The provider must ensure that staff are supported with appraisals, regular supervision and opportunities to update and further develop their clinical and leadership skills.
- The provider must ensure that staff always follow systems and processes to safely store and manage medicines.
- The provider must ensure that there is clear learning from incidents discussed with staff, both internal and external to the service and that managers and staff are made aware of the Learning from Deaths Mortality Review (LeDeR) Programme.
- The provider must ensure that physical health is consistently monitored and that all patient monitoring records about annual physical health checks are accurate.
- The provider must ensure that care plans are always reflecting the assessed needs and are always personalised, holistic and recovery-oriented.
- The provider must ensure that all staff are aware of care plans and positive behavioural support plans and use this information to enhance the quality of patient care.
- The provider must ensure that staff always assess and record capacity to consent clearly each time a patient needs to make an important decision where they might have impaired mental capacity.
- The provider must ensure that they carry out an autism friendly assessment to ensure that the environment is therapeutic for patients with autism and that the patient dynamics are adequately and regularly reviewed to ensure the environment is comfortable for all patients.
- The provider must ensure that the needs of patients with specific communication needs are met.
- The provider must ensure that governance processes operate effectively at all levels and that performance and risk are managed well.
- The provider must ensure that staff participate in clinical and internal audit processes to include mental capacity audit and that they function well and have a positive impact on quality governance.

Action the provider SHOULD take to improve

- The provider should ensure that emergency drugs are in date and available in the resuscitation emergency bags. Regulation 12(2)(b).
- The provider should ensure that managers always debrief and support staff after serious incidents. Regulation 18(2).

Outstanding practice and areas for improvement

- The provider should ensure that all patients have a hospital passport in place and it is fully completed. Regulation 9(3)(b).
- The provider should ensure that staff attend regular team meetings on wards. Regulation18(2)(a).
- The provider should ensure that staff know who the identified lead for Mental Capacity Act is and know where to get advice within the hospital regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. Regulation 17(2)
- The provider should ensure that families and carers are provided with information or signposted on how to access carer's assessment. Regulation 9(3)(g).
- The provider should consider that there is a sensory room at the hospital to meet the needs of patients.
- The service should ensure that all suitable adjustments are made to cater for disabled patients or visitors to access the premises. Regulation 17(1).
- The provider should ensure that there is clear learning and staff receive feedback on the outcome of investigations of complaints and acted on the findings. Regulation 17(2)(a)
- The provider should ensure that there is an active strategy to consistently promote equality and diversity in day to day work. Regulation 17(2)(b).
- The provider should consider that staff engage actively in local and national quality improvement initiatives. Regulation 17(2)(f).

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 Care plans did not always reflect the assessed needs and were not always personalised, holistic and recovery-oriented. 9(3)(b) Staff were not always aware of care plans and positive behavioural support plans to use this information to enhance the quality of patient care. 9(3)(b) The needs of patients with specific communication needs were not adequately met. 9(3) This was a breach of regulation 9

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 Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision where they might have impaired mental capacity. 11(1) This was a breach of regulation 11

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

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	The ligature risk assessments lacked clear actions on how the risk identified was to be managed. 12(2)(b) Staff did not always follow systems and processes to safely store and manage medicines. 12(2)(g) Physical health was not consistently monitored, patients with constipation had no care plans in place and bowel monitoring charts were not always completed. 12(2)(b) This was a breach of regulation 12
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 governance processes did not operate effectively at all levels and that performance and risk were not managed well. Staff did not participate in clinical and internal audit processes and they did not function well and had a positive impact on quality governance. The checks made by staff were not reliable and valid as a true reflection of what was held in the emergency bag in Moneystone. There was no clear learning from incidents discussed with staff, both internal and external to the service and that managers and staff were not aware of the Learning from Deaths Mortality Review (LeDeR) Programme. The provider did not carry out an autism friendly assessment to ensure that the environment was therapeutic for patients with autism and that the patient dynamics was adequately and regularly reviewed to ensure the environment was comfortable for all patients. This was a breach of regulation 17(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 18 HSCA (RA) Regulations 2014 Staffing All wards did not have enough nursing staff of all grades to meet the needs of the patients and no adequate systems and processes in place to mitigate the risks associated with high use of agency. 18(1) The provider did not accurately calculate and review the number and grade of nurses and support workers for each shift to allow staff to get rest breaks and regular breaks from enhanced observations according to NICE guidance. 18(1) There was clear leadership at ward level and that staff on duty were always experienced and had the right skills and knowledge to meet the needs of the patient group. 18(1) The provider did not ensure that the wards had good staff skill mix and that all staff including agency had received specific training to equip them with the right skills required for working with people with learning disabilities or autism. Staff had not received the necessary specialist training for their roles. 18(2)(a) The provider did not ensure that there was a comprehensive structured induction programme for agency staff to all the wards. 18(2)(a) Staff were not supported with appraisals, regular supervision and opportunities to update and further develop their skills. 18(2)(a) This was a breach of regulation 18