Derbyshire Community Health Services NHS Foundation Trust

Wards for people with a learning disability or autism

Inspection report

Ash Green Learning Disability Centre
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Ratings

Overall rating for this service	Good
Are services safe?	**Requires Improvement**
Are services well-led?	**Inspected but not rated**

Our findings

Wards for people with a learning disability or autism

Good 

Hillside ward is an assessment and treatment unit for adults with a learning disability or autism. To meet urgent local need, in September 2021, the service was reconfigured to meet the needs of people with a learning disability from Derbyshire awaiting longer term placements. One person was admitted from a secure environment at very short notice meaning not all the adaptations could be completed before admission. Bespoke, personalised staff teams had been deployed by the trust, Clinical Commissioning Group and Mental Health trust to meet the needs of the people using the service. At the time of our visit, the ward had three people with very high levels of need who were all being nursed in long-term segregation, in isolation from each other. The ward was not accepting further admissions. We carried out this unannounced focused inspection because we had received information raising concerns about the safety and quality of services.

We inspected parts of the safe and well led domains to gain assurance that people were being cared for safely. We did not fully rate this service at this inspection. The previous overall rating of good remains. However, we did re-rate the safe domain as requires improvement.

We found:

- Staff completed personalised care plans, positive behaviour support plans and risk assessments for people using the service. Staff had completed and kept up to date with mandatory training.
- Managers had increased available funds to purchase suitable resources and had agreed a full time occupational therapist for a time limited period.
- Although the service had experienced a loss of staff, existing staff and managers ensured the unit was adequately staffed.
- Managers had effective oversight of the care of all the people on the ward. Managers had put systems in place to manage the three separate staff teams. Agency staff worked to Hillside ward's risk assessments and care plans and saw the ward manager as having overall responsibility for care.
- Staff cared for people with respect and kindness. Staff ensured they applied the safeguards from the Mental Health Act Code of Practice to all three persons in long-term segregation.

However:

- The ward environments were not always clean and well maintained. The ward was not designed to meet the needs of people who required a secure environment. Making structural alterations to the layout of living areas was difficult due to the nature of each person's presentation.
- Staff supporting people using the service were not all trained in the same techniques for restrictive interventions. There were insufficient alarms for all the agency staff on the ward.
- People who used the service had different multidisciplinary arrangements in place as the service was short of permanent learning disability doctors and had to arrange cover from other services.
- The morale of some of the trust staff was low at the time of the inspection.

Our findings

How we carried out the inspection

Hillside is an assessment and treatment ward on the Ash Green learning disability hospital site. It is commissioned to look after six people from the age of 18 upwards, with expressing distress and/or agitation. At the time of our inspection, all three people were detained under the Mental Health Act. Both detained people and informal people can be admitted to the ward.

The ward had recently admitted two people who had previously been accommodated in secure wards outside of Derbyshire. When we inspected, the ward had three people, each nursed in long-term segregation. Managers had made changes to the layout of the ward to facilitate this. Managers had also decided there would be no further admissions until the three people using the service had moved to new placements.

Due to the high levels of need of the current people, there were separate arrangements for each person. Staff from Hillside ward supported one of the people while staff from two separate agencies supported the other two. These arrangements had been supported by the local Clinical Commissioning Group (CCG) as part of a system response to the urgent need to provide placements for vulnerable people with learning disabilities.

We carried out this inspection because we received concerns relating to staffing, care planning, restraint and staff engagement. We interviewed five managers, 14 staff and one advocate and reviewed all three care records.

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

What people who use the service say

We were able to speak to one person using the service on the day of our inspection and were able to get feedback from the advocate for the other two people. We spoke briefly whilst the person was interacting with staff.

Is the service safe?

Requires Improvement 

Safe and clean care environments

Safety of the ward layout

The three people were nursed in separate areas of the ward called bays. At the time of the inspection, all three people were nursed in long term segregation. The safeguards from the Mental Health Act Code of Practice had been applied in all cases.

Staff completed and regularly updated environmental risk assessments of all clinical areas and removed or reduced any risks they identified. Due to the high levels of staffing in place for each person, staff managed risks by observations and high levels of support and interaction.

The ward complied with NHS guidance and there was no mixed sex accommodation.

Our findings

There were some potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe.

Staff had access to alarms and all three people had easy access to nurse call systems. When the current care arrangements were put in place, the provider did not have sufficient alarms for a greatly increased staff team. There were not enough alarms to allocate to all the agency staff who were providing 4:1 staffing for one of the people using the service. In this bay, agency staff worked in teams of two. Two agency staff members and one Hillside staff provided individual support to the person and the agency staff teams rotated regularly and provided back up support when needed. Each agency team of two had to share an alarm. Staff managed this well and no incidents had arisen as a result. However, this could place staff and the person at additional risk. We raised this with managers during the inspection. They told us they had identified this as a risk and had ordered additional alarms. We saw evidence of this and the provider told us when replacement alarms had been received.

Maintenance, cleanliness and infection control

The ward had been partially adapted to cater for the current people living there. Some of the alterations had not been fully completed due to the difficulty in moving people with enough time to complete the work. Some of the woodwork was unpainted and maintenance were waiting to fit two new doors. There were cracks in one of the door frames and a notice board had been pulled off the wall by a person using the service. In one of the bathrooms, not used unsupervised by patients, there were some unsecured cables and pipes. This area was used by one of the people using the service under the supervision of two or three staff and kept locked when not in use. Staff told us they had requested that these be boxed in and managed this through enhanced observations. However, this had still not been completed several weeks later.

Parts of the ward were in need of redecoration. There were stains on the walls and ceiling in one of the bedrooms as well as in other rooms and corridors.

Not all parts of the ward were clean and well maintained. One person's bay, including their bedroom, utility room and corridor had dirty floors, windows and plug socket. We raised this during the inspection and staff rectified this before the end of the day and reviewed cleaning and maintenance plans for this area.

Staff followed infection control policy, including handwashing.

Safe staffing

The service was reliant on bank and agency staffing to ensure it had enough nursing and medical staff, who knew the people using the service well and received basic training to keep them safe from avoidable harm.

Nursing staff

The service was reliant on bank and agency staffing to ensure it had enough nursing and support staff to keep people safe. Each of the people using the service had their own staff team to provide care. As the original staff team at Hillside had not been sufficient to support the staffing levels required, separate arrangements had been made for each of the three people using the service. Two agencies each supported a person using the service, with some additional staffing and oversight provided by Hillside's permanent staff team. The Hillside staff team supported the third person. Agency staff reported to the ward manager and worked to risk assessments and care plans created by nurses on Hillside ward.

This arrangement had been notified to the CQC in mid-September 2021 and had been planned as a temporary solution by the trust, Clinical Commissioning Group and the mental health trust, to maintain the safety of the three people until longer term care options became available.

Our findings

These changes in the service on Hillside ward had contributed to staffing difficulties since the admission of two very complex people. Nine staff had left in the six months prior to the inspection and the service had not been able to replace them all despite active recruitment. The service had six registered nurse vacancies and three support worker vacancies at the time of the inspection. The trust stated their turnover rate over the previous 12 months was 17%. Managers and staff told us shifts had been covered by existing staff and by managers when needed. We reviewed rotas which supported this.

Managers used bank and agency staff for their own staff group and requested staff familiar with the service. This included staff from the trust's community learning disability and autism services. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The ward manager could adjust staffing levels according to the needs of the people they supported. Funding had been agreed by Clinical Commissioning Groups for additional staffing for the two people supported by agency teams.

Relationships with agencies had been problematic when the care packages were first set up as not all staff were regular, leading to some inconsistency of care in relation to one of the people using the service. During the inspection, three agency staff for this person told us they were either new or had not worked at the unit in the last weeks prior to their shift. However, staff and managers told us that although not all staff supporting this person were regular, this had improved over time.

Staff did not cancel activities or leave because of short staffing. People accessed section 17 leave after risk assessments had been completed. One person's leave had recently been cancelled for a period after a difference of opinion between professionals about the level of risk presented. However, this person did now access some leave, which we observed during the inspection.

Staff and managers told us they had increased the number of therapeutic activities for people using the service as they felt there had not been enough. Managers had bought additional resources and an occupational therapist was deployed full time on the ward for a six-month period.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep people safe when handing over their care to others. Where people were supported by an agency staff team, agency staff handed over information to the next shift and the registered nurse on the oncoming shift met with Hillside staff to update them.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. It had not been possible to provide medical cover consistently across the unit, meaning that each person had a different responsible clinician and a different multidisciplinary team. The local mental health trust supported the unit with psychiatric cover and the trust also deployed a psychiatrist from outside the trust to provide a second opinion for people using the service.

The trust had recruited two doctors due to start in January 2022.

Managers could call on locums when they needed additional medical cover.

Our findings

Mandatory training

Trust staff had completed and kept up to date with their mandatory training. Overall staff compliance with mandatory training was 91%.

The mandatory training programme was comprehensive and met the needs of people using the service and staff. However, staff said that given current people' needs, they would appreciate some additional mental health training and that working with agency workers had given them the opportunity to learn new skills.

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

Assessing and managing risk to people and staff

Staff assessed and managed risks to people and themselves well. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing emotional distress. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each person on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff produced risk assessments for all people on the ward. Agency staff teams followed risk assessments and care plans completed by Hillside staff and were responsible to the ward manager.

Management of patient risk

Staff knew about any risks to each person and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, people using the service.

Staff followed procedures to minimise risks where they could not easily observe people. They managed and mitigated risks to people using the service through enhanced observations and following positive behavioural support plans.

Use of restrictive interventions

Levels of restrictive interventions were reducing. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep people safe.

Not all staff working on the unit had been trained in the same restraint techniques when restraining one of the people using the service. Agency staff and Hillside ward staff both supported this person. Hillside staff had just received training in a new model of physical interventions. Agency staff we spoke with had received training in a variety of different models, meaning that if this person needed to be restrained, staff restraining the person may have may been trained to use different techniques. This could increase the risk of physical harm to the person being restrained. Managers told us they maintained consistent oversight of restraint techniques used for all three people using the service and that staff communicated well with each other to mitigate any risks. We did not identify any incidents where the person being restrained had suffered harm as a result of poor practices.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice when a person was put in long-term segregation. All three people using the service, at the time of the inspection, were detained in long-term segregation. Staff had implemented the safeguards of the code of practice in all cases.

Our findings

Safeguarding

Staff understood how to protect people 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.

Trust staff received training on how to recognise and report abuse, appropriate for their role. Over 90% of staff had completed levels one and two safeguarding children and safeguarding adults training and 85% had completed level three safeguarding children training. Managers told us agency staff were also up to date with safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily for two of the three people using the service. The third person's notes were accessible, including risk assessments, care plans and daily records. Incident reports completed by agency staff could not be accessed by ward staff until they had been signed off by managers for that agency, which could take up to seven days. However, Hillside staff also completed electronic incident reports for these incidents as a member of Hillside staff provided support to this person at all times.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. The ward was in the process of replacing paper records with electronic notes.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines.

We reviewed medication charts for each of the three patients. Staff followed systems and processes to prescribe and administer medicines safely. They reviewed each person's medicines regularly and provided advice to people and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date for all patients. Staff recorded patients' allegies and sensitivities to medicines clearly in patients' records.

Staff stored and managed all medicines and prescribing documents safely.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff gave us examples of strategies to avoid or reduce the need for high levels of medicines in line with patients' positive behaviour support plans.

Staff reviewed the effects of each person's medication on their physical health according to NICE guidance. GPs took the lead on physical health issues and liaised with doctors in the service.

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Our findings

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff reported serious incidents clearly and in line with trust policy. We reviewed incidents for all three patients for a three-month period and saw they were reported appropriately and acted on when needed.

Managers debriefed and supported staff after any serious incident. Staff confirmed this was happening. The psychologist had developed a training package to support managers to do this effectively.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for people using the service and staff.

The service had, against considerable odds, provided placements for three complex patients whose care and treatment presented huge challenges to the way the unit normally worked. The care arrangements that were put in place meant they had to establish practices outside their normal ways of working. Managers, including senior manager, and staff showed great ingenuity, determination and high quality multidisciplinary co-operation to make sense of a situation that was not ideal and was not of their own making. Although some difficulties remained and required action, there was a high level of commitment to make this work and to move people on to more appropriate placements.

Leaders were responsible for all the people on the ward. They made careful arrangements to co-ordinate care for all the people on the ward. Agency staff for the two people that received limited input from Hillside staff, reported to the ward manager.

Senior managers supported the service well. They worked closely with partner agencies to enable a bespoke solution for two people who required intensive support on a short-term basis. They oversaw structural alterations on the ward, supported the ward with additional managers to support staff, and enabled partners to arrange a personalised staffing structure that the service could manage.

The ward was also well supported by additional senior staff during this time, including the director of nursing, service managers and a second ward manager.

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Our findings

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Staff said that the past few months had been a difficult time. Staff felt the ward was being asked to support people who required a secure setting, which they were not accustomed to and for which they had not been trained. The needs of two of the people using the service had been assessed as requiring a secure care setting. As a result, some staff had left and morale had been low. However, staff also said this had presented opportunities for learning and development and morale was beginning to improve.

The arrangements to care for the three people on the ward had impacted on the staff team. Staff felt at times the care had been fragmented and there were different opinions about how to achieve the best outcomes for each person. Staff also noted they had learnt from agency staff who had additional training and experience in mental health and were accustomed to working in secure environments.

Staff said they felt able to raise issues without fear. Staff felt supported by their managers and were able to request their assistance when needed. Staff appreciated the extra support allocated to the ward during this period.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Hillside ward was an assessment and treatment unit for adults with learning disabilities and it's substantive staffing reflected this. It had recently been asked to take three extremely complex people, two of whom had been assessed as requiring secure care. The staff team was not experienced, skilled or of sufficient size to nurse all the people using the service effectively. The trust, supported by the Clinical Commissioning Group and the mental health trust, set up new arrangements in response to this challenge and to make it possible to admit these patients. Each person had their own staff team. One person was supported by ward staff, one person was largely supported by a single agency, with a constant presence by Hillside staff and another person was supported by a different agency with regular updates to Hillside staff, and face to face hourly enhanced observations undertaken by Hillside staff as well as medication and therapeutic interventions.

Managers had put systems in place to manage the current people on the ward. This included handovers from oncoming agency staff, regular sharing of information throughout the shift and ensuring that complex multidisciplinary team arrangements worked smoothly for each of the three patients. Managers had ownership and oversight of care plans, positive behaviour support plans and risk assessments for all three people. Managers said it had been a challenge to manage the different staff groups in this way and they had set up additional checks and procedures to maintain oversight where non-trust staff provided the majority of care.

Staff actively worked with commissioners to explore and facilitate more appropriate placements for people using the service. The trust worked with commissioners and with agencies to monitor and manage the staff teams.

Managers had actively recruited for staff to replace those who had left the service. They had also increased the occupational therapist to full time for a six-month period and appointed a new consultant psychiatrist to start in January 2022.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust Must take to improve:

Wards for adults with learning disability or autism

- The trust must ensure that all ward areas are clean and well maintained. (Regulation 15(1)(2)).

Action the trust Should take to improve:

Wards for adults with learning disability or autism

- The trust should ensure that when a person is restrained, all staff involved in that restraint are trained to work to the same restrictive intervention techniques. (Regulation 12).

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector. The inspection team was overseen by a Head of Hospital Inspection.