

Nottinghamshire Healthcare NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RHANM	Highbury Hospital	Orion Unit	NG6 9DR
RHANM	Highbury Hospital	Hucknall House	NG6 9DR
RHABL	Mansfield Community Hospital	Alexander House	NG18 5QJ

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Nottinghamshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Foundation Trust.

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Information about the service	8
Our inspection team	8
Why we carried out this inspection	9
How we carried out this inspection	9
What people who use the provider's services say	9
Good practice	9
Areas for improvement	10

Detailed findings from this inspection

Locations inspected	11
Mental Health Act responsibilities	11
Mental Capacity Act and Deprivation of Liberty Safeguards	11
Findings by our five questions	13
Action we have told the provider to take	25

Summary of findings

Overall summary

- Staff delivered person centred care in a kind and respectful way.
 - Staff completed patient assessments and reviews in a timely manner.
 - Patients and carers told us the service was good.
 - Patients had current care plans and risk assessments.
 - Care plans were recovery and outcome focussed.
 - Patients had a physical health assessment on admission to the ward and this was monitored throughout the patient admission.
 - Patients and carers told us the staff treated them with kindness, dignity and respect.
 - The staff team was made up of a range of professionals who worked effectively as a team.
 - Staff had good practical knowledge of the Mental Health Act and the Mental Capacity Act.
 - Staff told us they felt supported and confident about raising concerns.
 - Staff told us they felt happy and valued as team members.
 - Staff reported incidents and had systems to share learning.
- However:
- Identified staffing levels were not always met.
 - Activities only ran on Monday to Friday 9 – 5 and could be cancelled if staff shortages occurred. Patients told us they were bored without activities to do.
 - The seclusion and long term segregation facilities at Orion unit did not fully support patients' privacy and dignity.
 - Staff did not always complete mandatory training.
 - Patients did not always feel their complaints were acted upon.
 - Patients were not always given feedback on issues that they raised.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

- Identified staffing levels were not always met which meant sometimes the activities for patients were limited.
- The seclusion and long term segregation facilities at Orion unit did not support patients privacy and dignity.

However:

- The wards were visibly clean and tidy.
- The service contained a mix of staff from different professions and grades.
- The ward managers had the authority to adjust staffing levels to meet patients' needs.
- The clinic rooms were well equipped and staff regularly checked the equipment to make sure they treated patients safely.
- Each patient had a completed risk assessment, which was regularly updated, which meant the patients and staff were kept safe.
- Staff met the physical health needs of patients with thorough assessment and monitoring.
- There was a graded approach to supporting distressed patients and we saw detailed positive behaviour support plans.
- Staff used a range of assessments to assess patients' needs meaning care and treatment was holistic.
- Staff knew how and when to raise safeguarding alerts.
- We saw evidence of the duty of candour with apologies being offered when things went wrong.

Are services effective?

- Staff assessed each patient's needs on admission and regularly reviewed them.
- Care records were recovery focussed, up to date and personalised so patients were treated as individuals.
- Staff assessed patient outcomes on an on-going basis using recognised tools.
- The multidisciplinary team was made up of a range of professionals.
- Staff received regular supervision.
- Staff had good practical understanding of the Mental Health Act and the Mental Capacity Act.
- The staff worked collectively as a team to meet patients need.

However:

Summary of findings

- Bank staff could not access the electronic records system, which posed a risk to patients because they could not see all the information about the patient.
- Staff mandatory training compliance at Alexander house was low, which could mean staff were not adequately trained for their roles.

Are services caring?

- Patients told us they were treated with respect and dignity. The interactions we observed were respectful of the individuals and upheld their dignity.
- Patients told us that staff were kind and treated them well.
- Staff involved patients in the planning of their care.
- Patients could access advocacy services.

Are services responsive to people's needs?

- There were beds available to meet patient need.
- Discharge planning included the patients and was reviewed and updated throughout their stay on the wards.
- Patients had access to fresh air and outdoor space.
- People with disabilities, including wheelchair users, could access the ward.
- Patients told us they felt confident to raise complaints. Staff knew how to address complaints.

However:

- Patients did not always feel their complaints were acted upon.
- Two staff members told us that patients normally complain through them. We had concerns that this meant patients may feel uncomfortable making complaints, especially if staff were part of the complaint.
- Staff did not always give patients feedback on issues that they raised.
- Activities only ran on Monday to Friday 9 – 5 and could be cancelled if staff shortages occurred. Patients told us they were bored without activities to do.

Are services well-led?

- Staff knew who senior members of the organisation were.
- Staff told us they were happy in their roles and worked together as teams.
- Staff told us they felt valued and supported.
- The wards had systems for monitoring mandatory training.

Summary of findings

- Staff told us they would be confident to raise concerns without fear of victimisation or reprisals.

Summary of findings

Information about the service

Nottinghamshire Healthcare NHS Foundation Trust wards for people with learning disabilities or autism provide specialist in-patient health mental health services for people with intellectual disabilities, focusing on those whose needs cannot be met by mainstream provision.

The Orion unit is an 18 bed mixed gender inpatient unit providing assessment and treatment. For those people with an intellectual disability and associated challenging behaviour and mental health issues, who cannot be managed in the community at the time of their admission.

Hucknall house has five beds and provides a short break service for adults with a learning disability and associated behaviours and/or physical health needs; who cannot be supported anywhere other than a specialist health provision. Hucknall house was due to close in the weeks following the inspection.

Alexander house has eight beds, for males only. It provides a step down from low secure provision. The focus is on rehabilitation and reintegration into community settings for those patients who have a history of offending behaviours.

The service was last inspected between the 29 April - 2 May 2014.

The service was issued with three compliance actions, which have now been met.

Regulation 9 (1) (a) (b) (i) (ii)

The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by means of carrying out of an assessment of the needs of the service user and the delivery of care and treatment to meet the service user's individual needs and ensure their welfare and safety.

The way the Regulation was not being met:

People's support plans and assessments of potential risk did not sufficiently detail how staff were to safely support each person and ensure they were treated in the least restrictive environment.

There was insufficient monitoring and recording of people's physical health needs in Orion unit.

Regulation 11 (2) (a) (b)

The registered person did not have suitable arrangements in place to protect service users against the risk of control and restraint being unlawful or otherwise excessive.

The way the Regulation was not being met:

There were no care plans or risk assessments in place on Orion Unit to demonstrate why staff were using the low arousal suite and how staff were to support the person to minimise any risks to their safety and wellbeing.

Regulation 20 (1) (a)

The registered person must ensure that service users are protected against the risks of unsafe or inappropriate treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user, which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

The way the Regulation was not being met:

Section 17 leave forms were not specific to individuals and the specific period of leave. Records for people who used the service did not include detail to guide staff in how to support the person if they became aggressive and needed staff to physically intervene to ensure their safety and that of others.

Our inspection team

The team was comprised of:

- an inspection manager,
- five CQC inspectors,
- two experts by experience, these are people who have experience of learning disability services

Summary of findings

- a specialist advisor, and
- a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this core service as a follow up to a comprehensive inspection previously completed, to assess if the compliance actions issued had been met.

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 we held about the service.

During the inspection visit, the inspection team:

- visited three wards on two different hospital sites and looked at the quality of the ward environments and observed how staff were caring for patients.
- spoke with seven patients who were using the service.
- spoke with four carers.

- interviewed the modern matron for the service.
- spoke with the managers or deputy managers for each of the wards.
- spoke to fifteen other staff including doctors, qualified and unqualified nurses of various grades, a speech and language therapist and a student nurse.

We also:

- looked at eight treatment records of patients.
- reviewed two medication charts.
- attended and observed two hand-over meetings.
- attended two multi-disciplinary meetings (MDT's).
- attended two patient activities.
- attended one patient review.
- looked at a range of policies, procedures and other documents relating to the running of the wards.

What people who use the provider's services say

Patients told us they felt respected and well looked after. They also told us they liked the staff team and staff were good to them. Patients and carers told us staff understood the individual needs of patients and staff

provided practical and emotional support. Two relatives told us they felt the patients were safe. Relatives and patients at Alexander house spoke very positively about their improvements since moving there.

Good practice

The service used a good range of communication tools and techniques to make sure they communicated with patients as effectively as possible. We saw easy read formats and with pictures to aid understanding. Staff

used object reference to give patients options. Objects were used to give individuals an idea of what was about to happen. For example, staff giving someone a spoon indicates it's time to eat or a towel and they know it's time

Summary of findings

to shower. Staff used the Somerset total communication tool to try to develop a common meaning of language. Communication talking mats were used to enhance the communication between staff and patients.

Areas for improvement

Action the provider MUST take to improve

Ensure that there are sufficient, suitably qualified, competent, skilled and experienced staff to provide a comprehensive service to patients.

Action the provider SHOULD take to improve

Ensure that all staff, including bank staff, have the necessary training and access to computer systems to complete their roles.

Ensure that activities are provided seven days a week throughout the patient waking day.

Review the systems to ensure that complaints and concerns are acknowledged, addressed and that patients receive prompt feedback at Orion unit.

Review the seclusion/ segregation facilities at Orion unit to improve the privacy and dignity of patients.

Nottinghamshire Healthcare NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Orion Unit	Highbury Hospital
Hucknall House	Highbury Hospital
Alexander House	Mansfield Community Hospital

Mental Health Act responsibilities

- We checked the records of five detained patients at Orion unit and found the Mental Health Act (MHA) detention documentation was clearly evident in the patients' records.
- Staff were aware of the independent mental health advocacy (IMHA) service. In four of the five records we reviewed it was documented the patient had been informed of the IMHA service.
- MHA support is provided to the wards from a trust central team.
- Orion unit had an up to date seclusion/ therapeutic segregation policy with regard to the new MHA code of practice.
- There was inconsistent recording of patients being read their section 132 rights and this being repeated on an on-going basis, this could have meant patients were unaware of their right to appeal or a tribunal.
- We saw easy to read rights leaflets. This meant patients had easily accessible information.
- Recording of capacity to consent to treatment was inconsistent. We found no evidence of this in two sets of records.
- Staff had training in the MHA. Compliance levels of training varied, Alexander house had 11 of 19 staff trained or 58%. Orion unit had 33 of 39 staff trained or 85%. Hucknall house had 9 of 10 staff trained 95% compliance. Staff we spoke to had a good working knowledge of the MHA.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Orion ward had five patients who were subject to deprivation of liberty safeguards (DoLS). Qualified staff spoke confidently about DoLS. They were clear all decisions were specific and told us they would involve families and carers in decisions being made. Decisions would be recorded in patient care records. We viewed one set of notes where the patient was subject to DoLS and found that the legal papers were in order and a standard authorisation had been made.
- Staff training in the Mental Capacity Act (MCA) varied across the wards. Alexander house being the lowest at 74%, 14 of 19 staff had completed. Orion unit was at 95% where 37 of 39 staff had completed the training. Hucknall house was 100%, all 10 staff completed.
- There was a policy on the MCA and DoLS staff could refer to.
- All records had a capacity assessment present but these were not always detailed or specific.
- We witnessed a discussion regarding a lack of capacity and the need for a best interest's decision to be made. The discussion was specific to an identified need and involved the MDT team and included the patient.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The ward environments were clean and tidy. Patient led assessments of the care environment (PLACE audits) were completed. The outcomes were positive. Orion unit received a pass mark throughout. The rater recorded they were confident the environment supported good care. Alexander house received a pass or qualified pass on all areas. A qualified pass means there were minor areas to improve on but not enough to lower the rating. The rater reported being confident that the environment supported good care. Hucknall house achieved a pass mark, with a couple of areas receiving a qualified pass.
- Monitoring of infection cleanliness and environment (MICE audits) were completed, with overall scores between 97- 98%, which is an excellent rating. Previously a recording of 90% was seen as unachievable in mental health services.
- The furniture throughout the wards was in good order.
- We found the clinic rooms were well equipped. We saw staff checked fridge and room temperatures daily to ensure the safe storage of medicines on all wards. Orion unit and Alexander house had accessible resuscitation equipment and emergency drugs we saw staff checked weekly.
- Hucknall house clinic room did not contain a couch or emergency equipment, Hucknall house had been assessed as a low risk environment. Emergency equipment was at Orion unit approximately 5 minutes away. Hucknall house staff told us if there was a medical emergency they would ring 999 immediately to mitigate this risk.
- Hucknall house did need repainting but was due to close.
- We saw evidence annual environmental risk assessments were undertaken in each ward. Risks could be escalated to the directorate risk register as part of this process.
- The layout of the wards did not allow for full observation of patients. Orion unit had closed circuit television (CCTV) monitoring in its communal areas that helped to mitigate the risk. CCTV covered the seclusion, therapeutic segregation areas and two bedrooms when additional observations were required. An example given by staff, if someone required observation throughout the night due to epilepsy. We saw that there was a policy that covered the use of CCTV.
- It is important that staff are able to observe patients who may be at risk. Staff knew about the issues with poor lines of sight and individual patients were risk assessed for the level of observation required. During inspection we saw staff members observe patients to minimise the risks in all wards.
- We saw evidence that ligature point assessments were completed. Ligature points are places to, which patients intent on self-harm might tie something to strangle themselves. The wards had anti-ligature fittings and collapsible rails for curtains and blinds. Individual patients were risk assessed this meant that the risk of ligature was minimised helping to keep patients safe.
- Orion unit was a mixed gender ward with all bedrooms en-suite. There were separate male and female toilet facilities on the ward. There were single gender lounges but on the day of our visit these were not being observed. We asked staff regarding single gender lounges and were told this would be accommodated if a patient expressed a preference or if there was an identified risk. Both Hucknall and Alexander house were male only environments.
- There were appropriate alarm systems and nurse call systems in place at Alexander house and Orion unit. We heard the alarms sound during our visit. Hucknall house did not have a call system, which means that patient's with limited communication would not be able to call for assistance.
- We saw that medication reconciliation occurred at the point of admission and discharge. At Hucknall house medication was checked with day care facilities to ensure the patients received the correct medication.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Alexander house lounge could only be accessed when a staff member was present due to the difficulties with observation from the staff base.

Safe staffing

- Seven of fifteen staff told us that the wards were regularly short staffed.
- Between April 1st 2015 and the day of inspection: Orion unit had requested 1027 bank shifts of, which 783 had been filled; a further 102 shifts had been filled by agency staff, meaning that 14% of shifts were unfilled. Alexander house had requested 337 bank shifts of, which 310 had been filled and a further three had been filled by agency staff, meaning that 7% of shifts were unfilled.

To try to mitigate the shortfall we were told that deputy and ward managers and activity workers at Orion unit would cease to be supernumerary to fill gaps or staff would be deployed from other parts of the hospitals.

- Two activities co-ordinators worked Monday to Friday at Orion unit to facilitate activities and leave. However, two patients told us that sometimes escorted leave is cancelled due to not enough staff. One patient said this happened especially if someone was on 2:1 observations.
- Wards had sufficient staff to carry out physical interventions during the day. At Alexander house and Hucknall house two staff worked at night, which meant, if needed physical intervention or restraint could not be safely carried out. However, neither ward had had any incidents that required more than two staff in the previous four months.
- Staff told us that patients received regular 1:1 time with their named nurses. Patients we spoke to confirmed this but said sometimes they had to wait.
- The ward staffing levels and skill mix were determined at trust level.
- Ward managers had the authority to adjust staffing levels daily to meet patient need. On the day of our visit staffing levels were met. Orion unit had two extra staff on duty to meet patient needs.

- Regular bank staff were employed to meet staffing levels. Staff members we spoke with confirmed they worked extra bank shifts to meet patient need. Agency staff were only used if the bank were unable to fulfil requests.
- Throughout our visit a qualified nurse was present in the main communal areas. Staff and patients told us this was always the case.
- We saw there were medical staff based on the wards. Staff informed us medical staff on-call would respond out of hours within a maximum of 30 minutes depending on the distance they needed to travel.

Assessing and managing risk to patients and staff

- Orion house was the only ward that used seclusion and long term segregation. We reviewed appropriate seclusion monitoring documentation.
- We had concerns about the privacy and dignity of patients using this facility. Whilst we were touring the ward we saw there was an observation area outside the two seclusion / long term segregation rooms, which was behind large glass windows. We saw two staff in the area each observing one patient. Patients in the two separate rooms could see each other, at the end of the room through the glass. Anyone walking along the main corridor when the door to the area was open would be able to see the patients. We were told the rooms had poor soundproofing and there was the potential for patients to disturb each other. We were concerned this undermines the principle of 'therapeutic' segregation. Therapeutic segregation is where a patient is moved to a quieter environment to enhance their well-being.
- We also noted some confusion in relation to the terminology used by staff to describe the seclusion and long term segregation areas. We heard the terms, 'low stimulus' used and 'acute area'. We were concerned this could lead to confusion and a lack of clarity regarding patient treatment plans and associated monitoring.
- Staff told us restraint is only used if de-escalation techniques have failed. We saw evidence in care plans of a graded approach in patients' positive behaviour support plans. We found these plans were detailed and clear. This would mean that patients were effectively supported by staff and interventions would be appropriately used.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Since April 2015 Hucknall house had no incidents of restraint recorded. Alexander house had five recorded incidents of restraint, described as passive holds to prevent harm to another person. Orion unit had 10 incidents of restraint within the same time period this excluded passive restraint.
- Rapid tranquilisation had not been used across the wards.
- Eight care records were reviewed; each record had a risk assessment present, which was completed as part of the admission process. The historical clinical risk management tool was used to assess risk. Alexander house also used risk assessment management plans. We found risk assessments were detailed and reviewed periodically. We found examples where a risk had been identified and a corresponding care plan had been initiated. This meant risks were effectively assessed and managed.
- Records we reviewed contained a thorough detailed assessment of physical health needs at admission and demonstrated on-going review occurred and specialist referrals were made if needed. This meant that patient's physical health needs were fully assessed and monitored.
- Staff shared an example of positive risk taking. Patients at Alexander house had been on a group activity of abseiling. This meant the team was not afraid to take risks with the patients to improve their wellbeing.
- No ward had a list of restricted items. Alexander house did not permit the use of mobile phones. Other restrictions were assessed on an individual basis depending on risk.
- Staff told us room searches were carried out at Alexander house. Patients told us this didn't happen very often. If searches did occur two staff members carried out the search and the patient sat by their bedroom door and observed; patients confirmed this was the case.
- All units had a locked door. Patients at Orion unit and Alexander house were either detained under the Mental Health Act or subject to deprivation of liberty safeguards restrictions on the day of the inspection. We saw at Orion unit information was displayed of an informal patient's right to leave. Hucknall house provided respite or short break and staff felt patients would not consider leaving. It had a locked door policy that emphasises the prevention of unwanted persons from entering the unit to protect the patients. Hucknall house staff told us that if someone wanted to leave they would try to understand why and involve carers. We found information on display on the wards informing voluntary patients of their rights.
- The staff that we spoke to were clear how to raise a safeguarding alert. Orion unit had raised 18 safeguarding alerts in the previous 12 months. Completed training figures for safeguarding adults were 65 of 71 staff (90%), and children 66 of 71 staff (95%) across the three wards. Hucknall house had 100% compliance with safeguarding training. At Alexander house we observed a detailed discussion regarding a recent safeguarding incident. This means staff were aware of their responsibilities and took measures to protect patients from abuse.
- Wards routinely completed assessments to minimise health risks. The Braden tool was used to assess pressure ulcer risk. Screening assessments for falls prevention and for venous thromboembolism risk were completed.
- Visiting occurred in the visitors room, this facility was off the main ward areas and was accessible for both adult and child visitors. At Alexander house the suitability of children visiting was risk assessed on an individual patient basis. We found the visitors rooms to be well furnished and comfortable.

Track record on safety

- There were recorded incidents for all wards.
- Orion house reporting 291 incidents in a four month period. Of these incidents 250 related to five patients, of the five patients, three subsequently moved to another facility to meet their needs.
- Hucknall house reported 20 incidents, six of these incidents related to low staffing levels, in four cases staff from Hucknall house had been re-deployed to other service areas leaving Hucknall house below agreed safe staffing levels and on two occasions without a qualified nurse for a period of time. Hucknall house had a lone-worker policy.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Alexander House had reported 43 incidents in the four month period.
 - We saw in team meeting minutes and observed during clinical meetings information was shared with team members and there was discussion regarding learning.
 - The Trust had an action plan dated October 2014 to challenge restrictive practices in local services that was progressing as planned. Areas covered included “no force first”-an initiative to support patients through methods other than physical and medication-led restraint. A review of observation, section 17 and ground leave policies. A blanket restrictions working group and a review of RIO (electronic patient records) recording.
 - We saw evidence within incident reports when things went wrong this was acknowledged and shared with patients and carers, with an apology given, demonstrating the services commitment to the duty of candour.
 - Feedback from incidents or investigations was shared with staff either electronically via e-mail, via multidisciplinary meetings, handovers or via team meetings. We observed recent incidents being discussed at a clinical meeting and a handover.
 - Staff told us that following incidents they were offered debriefing, one staff member told us this is offered but not always accepted. We were told that debrief with patients happened after incidents; this was facilitated via a review of care plans with the patient.
- Reporting incidents and learning from when things go wrong**
- All staff spoken with confidently described incidents that should be reported and how they would do this.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Of the eight care records we examined, all had a comprehensive and timely assessment of need completed. This meant that patient needs were identified and care planned so they were met.
- The quality of physical health assessment and monitoring was robust and thorough. All care records contained an initial physical health assessment and showed clear evidence this was reviewed and monitored on an on-going basis; ensuring physical health needs were met.
- Care records were recovery focussed, up to date, personalised and holistic. This indicated patients were treated as individuals.
- Care plans were very detailed and contained information about how to best communicate with the individual patients. We saw the use of likes and dislikes charts, which provided useful information of how to communicate with individuals.
- There was variation in the standard of patient files with some very organised and others less so.
- Patient paper records were stored appropriately in the ward offices, which we observed to be locked at all times. Patient records were also kept electronically on the RIO system. One bank member of staff told us they were unable to access the RIO system; this could have meant not all current information was available, which could have created a risk to patients.

Best practice in treatment and care

- There was a wide range of psychological therapies available to patients. The care records we reviewed contained care plans detailing psychological interventions. The wards used the trust psychological therapy pathway as guidance.
- The national institute for health and care excellence (NICE) guidance informed the prescribing of medication and was used to inform interventions offered. For example, NICE guidance on attention deficit hyperactivity disorder: and NICE obesity guidelines. This ensured patients received care of a nationally agreed standard.

- Various communication tools were used. We saw that the Somerset total communication tool was used to try to develop a common meaning of language. Communication talking mats were used to enhance the communication between staff and patients.
- Health of the nation outcome scales (HoNOS) rating scales were completed within the records we reviewed. HoNOS is a nationally recognised
- Staff were involved in the completion of audits at ward level. We saw that the clinic room equipment was regularly audited. We were told following an audit of Section 17 leave, late last year; paperwork had been amended to ensure that all necessary information was recorded.
- Each ward had clear links established with the epilepsy liaison service.

Skilled staff to deliver care

- The ward teams were made up of a good range of disciplines; medical staff, nurses and health carers, psychologists and assistants, occupational therapists, physiotherapists and speech and language therapists. Social workers were part of the multidisciplinary team but not employed by the trust. The hospital pharmacist visited the wards weekly and completed medication reconciliation on admission. This meant there was a good range of professionals to support patients holistically.
- We saw records of regular staff supervision. Staff received supervision monthly. Staff valued supervision. The medical consultant's supervised junior doctors weekly via a case based discussion. One nurse informed us they were receiving weekly supervision as they had just returned to work following a period of absence. The nurse felt this was positive and supportive.
- There was a mix of experienced and newer staff members on the wards. A student nurse told us they had felt welcomed to the ward and valued their learning experience. We were told bank staff would be block booked to try to enhance continuity and meet patient need.
- Staff mandatory training was addressed at individual ward level. Hucknall house had ten staff; compliance was in excess of 90% with most areas scoring 100%. One member of staff was not up to date with fire training and

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

another member of staff was not up to date with management of violence and aggression training. Orion unit had 41 staff; compliance was in excess of 85% apart from care programme approach (CPA) training, which scored 57%. Eight of fourteen staff had completed CPA training; we saw that the other six staff were booked to complete this training. Alexander house had low compliance in relation to several areas of training. Mental Capacity Act (MCA) 14 of 19 staff had completed this training (74%). Mental Health Act (MHA) training had been completed by 11 of 19 staff (58%). Manual handling had been completed by 11 of 20 staff (55%); we saw that there were plans for three staff to complete this. Breakaway training had been completed by 2 of 3 staff (67%); we saw that one person was booked to complete this. This could have meant staff were not fully trained to complete their roles.

- Staff had regular team meetings and we saw minutes to support this. Team meetings were used for information sharing but also as a venue for staff to raise ideas or issues.
- Staff training and development was available. We spoke to one staff member who had originally worked as a domestic but had then taken up a healthcare role. Other training completed included mindfulness training, working with personality disorders and attendance at rehab and recovery seminars.
- Healthcare workers had opportunities to lead patient activity groups such as healthy living and cooking.

Multi-disciplinary and inter-agency team work

- As part of our visit we observed two handovers, which were multidisciplinary. We found there was thorough discussion of each individual patient. This included future planning and a review of risk. Issues were highlighted and staff members identified to address these. This meant that risks were identified and actions taken to address them.
- We observed two MDT's, which included a range of professionals, we noted that interactions were relaxed and staff members contributed to the discussions.
- The wards held daily handovers between the changes of shifts. We observed these were attended by various professionals groups, which meant the sharing of information was enhanced.

- We observed a discussion regarding the need to involve a member of the community assessment team to facilitate a successful discharge. We were told that community staff remained involved in patient care during the admission period to maintain relationships. At one CPA there was a member of community staff present. This meant information sharing and continuity of care for the patient was present.
- Other discussions we witnessed indicated that relationships existed with external agencies; this would mean there was a greater range of options available to the patients.
- We witnessed a discussion where the clinical team raised concerns in relation to a patient. The team did not feel supported as local safeguarding and clinical commissioning did not support their clinical judgement. This could mean services were working with patients who they did not feel they had the ability to effectively treat.

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

- We checked the records of five detained patients at Orion unit and found the MHA detention documentation was clearly evident in the patients' records.
- Staff were aware of the independent mental health advocacy (IMHA) service. In four of the five records we reviewed it was documented the patient had been informed of the IMHA service.
- MHA support was provided to the wards from a trust central team.
- Orion unit had an up to date seclusion/ therapeutic segregation policy with regard to the new MHA code of practice.
- There was inconsistent recording of patients being read their section 132 rights and this being repeated on an on-going basis, this could have meant patients were unaware of their right to appeal or a tribunal.
- We saw easy to read rights leaflets. This meant patients had easily accessible information.
- Recording of capacity to consent to treatment was inconsistent. We found no evidence of this in two sets of records.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff had training in the MHA. Compliance levels of training varied, Alexander house had 11 of 19 staff trained or 58%. Orion unit had 33 of 39 staff trained or 85%. Hucknall house had 9 of 10 staff trained 90% compliance. Staff we spoke to had a good working knowledge of the MHA.

Good practice in applying the Mental Capacity Act

- Orion ward had five patients who were subject to deprivation of liberty safeguards (DoLS). Qualified staff spoke confidently about DoLS. They were clear all decisions were specific and told us they would involve families and carers in decisions being made. Decisions would be recorded in patient care records. We viewed one set of notes where the patient was subject to DoLS and found that the legal papers were in order and a standard authorisation had been made.
- Staff training in the Mental Capacity Act (MCA) varied across the wards. Alexander house being the lowest at 74%, 14 of 19 staff had completed. Orion unit was at 95% where 37 of 39 staff had completed the training. Hucknall house was 100%, all 10 staff completed.
- There was a policy on the MCA and DoLS staff could refer to.
- All records had a capacity assessment present but these were not always detailed or specific.
- We witnessed a discussion regarding a lack of capacity and the need for a best interest's decision to be made. The discussion was specific to an identified need and involved the MDT team and included the patient.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We observed patients were treated with respect and dignity and appeared relaxed interacting with staff.
- We noted during a multidisciplinary meeting the patient was allowed time to voice their views and opinions.
- We observed through individualised care plans patients' needs were identified and met.
- We were told by the patients most staff were kind and treated them well; 'they look after me'. Patients said staff always knocked on bedroom doors before entering.
- Patients at Orion unit and Alexander house had keys to their bedrooms, if assessed as safe to do so. This demonstrated the staff respected the patients need for privacy.

However:

- Two patients told us night bank staff were negative towards them and refused requests. One patient told us they had complained and nothing had been done. We were later informed that a bank member of staff had been spoken to by the ward manager and no longer works on the unit.

The involvement of people in the care that they receive

- Patients were orientated to the ward on admission; this was confirmed by patients we spoke to.

- We saw patients were involved in their care planning both through their care plans and by our observations of a clinical review. We noted the patient was able to ask questions and express concerns and staff were responsive to requests made.
- Care plans at Hucknall house were in easy read format, with pictures to aid understanding. Staff told us there was a lot of object reference used to give patients options. Objects can be used to give individuals an idea of what is about to happen. For example giving someone a spoon and they know it's time to eat or a towel and they know it's time to shower.
- Not all care plans were signed by the patients although it was recorded that care plans had been offered to the patients.
- Staff told us about advocacy services and we saw easy to read advocacy leaflets displayed. Two patients we spoke with were aware of advocacy services; this meant patients had assistance if needed to express their views.
- Three carers told us staff were responsive to any questions they had, both in person or by phone. One patient told us that their mother always came to their meetings. A carer told us a concern they raised had been dealt with swiftly and they were satisfied with the outcome.
- We found information regarding the Care Quality Commission on display and of the local advocacy service provided.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- We were told that access to a bed was not an issue. During our inspection all units were under capacity. Orion had 13 beds filled out of 18. Hucknall house had 2 beds filled out of 5 and Alexander House 7 out of 10.
 - Discharge planning was part of an on-going process from the point of admission. At Alexander house the aim was to work with patients to facilitate discharge within 18 months. We observed how staff were planning effective supported discharges through multidisciplinary meetings.
 - Two patients and a carer told us that since moving to Alexander house plans were in place for discharge. The carer told us they felt this was incredible and that without the support of Alexander house staff the patient would not have been able to move on.
 - Staff told us that sometimes discharges can be delayed due to the lack of availability of suitable placements. They felt this was unfair and had a negative impact on patient's wellbeing. On the day of the visit we were not informed of any delayed discharges.
- There was a choice of menu daily; often the second choice would be sandwiches or soup. We reviewed a months' worth of menus and found that attention was given to cultural or dietary needs within these.
 - Recent PLACE audits of food assessment completed at the Orion unit and Alexander house were positive. Alexander house received an improvement of over 15% on their rating this year compared to last year and was above the national average.
 - Patients told us that there was little choice regarding mealtimes and the quality of the food varied.
 - We saw and were told by patients at Orion unit and Alexander house they were able to personalise their bedrooms. This was risk assessed on an individual basis for items allowed. One room a patient showed us had a large TV, sports memorabilia and a games console. At Hucknall house no bedrooms were personalised but this may have been due to the short stay nature of the ward and also the ward was due for imminent closure.
 - Kitchen facilities were locked but patients could have a hot or cold drink if they requested, patients confirmed this when asked. The kitchen was locked because drinks had been used as weapons when fully accessible by patients. We observed hot drinks being freely served to patients during a group activity.

The facilities promote recovery, comfort, dignity and confidentiality

- There was access to outside space, wards had garden areas. At Orion unit patients could access outside space freely; meaning access to fresh air was available to patients. Orion unit had outdoor garden space directly off their seclusion/ segregation facility meaning patients using this facility also had access to fresh air. At Hucknall house and Alexander house outside space was available but patients could only access it by request. We were told doors were kept locked for risk and safety reasons. Patients at Alexander house told us their requests were always granted.
 - Smoking was at designated times throughout the day from 8am until 8pm at Orion unit and Alexander house, in a designated part of the garden. Hucknall house was a no smoking facility.
- At Alexander house patients completed their own laundry as part of their rehabilitation. Patients told us about shopping trips and activities they completed within the community, both escorted by staff and unaccompanied. One patient told us they accessed a local gym for two hours, four times a week.
 - Patients at Orion unit and Alexander house had their own keys to their bedrooms if they were assessed as safe to do so. Access to bedrooms at Hucknall house was only restricted if the patient had repetitive behaviours and this would be care planned.
 - There were well equipped clinic rooms and a range of other rooms to carry out activities. We noted that due to the circular layout of Orion unit the designated space used for a coffee morning activity felt very busy. Patients could be distracted by people passing and the high noise levels could impact on the patient's ability to focus on the activity.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- At Alexander house most patients were in the activity room as the lounge was locked due to it being difficult to observe from the staff base. Hucknall house patients continued to attend day care whilst inpatients and were not present during our inspection.
- There were visiting facilities off the main wards, which we noted were comfortably furnished.
- Orion unit had a pay phone that was in a discreet private area.
- Alexander house did not have a pay phone. Patients at Alexander house could use the ward phone. This would mean patients did not have private access to a telephone for personal calls.
- Two activity co-ordinators worked at Orion unit providing a programme of activities Monday to Friday between 9.00am and 5.00pm. Some patients told us they enjoyed the activities, one patient said 'bingo is best'. Patients at Alexander house had individual activity plans. Patients told us of the varied activities they enjoyed.
- Patients consistently told us there was nothing to do at the evenings or over the weekend and they were bored. Five patients told us activities were limited due to low staffing levels. We were concerned that patients told us they could only complete activities they enjoyed once a week due to low staffing levels. At Hucknall house we noted there were limited arts and craft equipment and games available.
- Patients and staff at Alexander house told us if band two staff were on duty they were not able to have community leave. Band two staff were not permitted to carry out community leave.
- We asked about the use of interpreters and were told this could be arranged. Orion unit had used one interpreter in the previous four months, the other wards had not.
- We were told patients could follow their own religious preferences; one patient at Alexander house regularly attended church. A carer told us that her son used to really enjoy going to church but he no longer attended, she did not know why this was.
- Hucknall house had a sensory room but most of the equipment had been removed due to the imminent closure.
- All patients at Hucknall house had communication plans, which highlighted preferences on food, drinks and how they like their medications. This meant individual patient preferences were met.
- The speech and language therapist prepared individual tailor made communication aids for individual patients if needed, we saw evidence of this in patient records.

Listening to and learning from concerns and complaints

Meeting the needs of all people who use the service

- Patient's with disabilities, including wheelchair users, could access the wards.
- All leaflets displayed were in English only. Staff told us these could be translated via the trust if needed. Information displayed was in an appropriate easy read format.
- Community meetings were held monthly, we saw minutes of these. The minutes of meetings included a section 'you said - we did', we saw actions identified had been met, for example, a patient had been helped to access an optician appointment and been fitted with glasses. Another patient had asked to go out more and had been to a local park. At Alexander house the minutes from a recent meeting were displayed on a notice board using easy to read pictorial aids.
- Staff were able to tell us the appropriate process for dealing with complaints.
- Patients and carers told us they would be confident to raise concerns or complaints. One carer told us they had raised a concern by e-mail that had been dealt with swiftly and they were satisfied with the outcome.
- No formal complaints had been received across the three wards.
- One patient told us they had complained about bank night staff and nothing had been done. We were later told this had been addressed and resolved. The patient was unaware of this.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- There were no leaflets available on how to complain at Orion unit. We were told they were normally kept in the reception area but they had been ripped up by a patient the previous night. There were no information leaflets on how to complain at Alexander House. Leaflets were available at Hucknall house.
- Two staff members told us patients would normally complain through them. We had concerns that this meant the patient's may feel uncomfortable making complaints, especially if staff were part of the complaint.
- Patients had raised issues in the community meetings. By reviewing the minutes of the meetings at Alexander house we were able to see issues had been explored. Feedback had been given. This demonstrated patient's views were valued. At Orion unit the minutes did not reflect what actions, if any, had been taken in response to the issues raised. Patients were not given feedback to their concerns or requests this did not demonstrate that the patients were respected or valued.
- Hucknall house sent out a feedback form to patients once discharged.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff we spoke to knew who senior members of the organisation were and we were told they had visited the wards.
- Staff told us that the trust vision supported the 6 c's; a national initiative to improve the quality of care. Staff were aware of the trust quality priorities, for example, one healthcare told us about the staff working as a team to provide consistency for the patients.

Good governance

- We found that mandatory training was available and that compliance levels were good. Alexander house had low compliance in relation to several areas of training. Mental Capacity Act 14 of 19 staff had completed this training (74%). Mental Health Act training had been completed by 11 of 19 staff (58%). Manual handling had been completed by 11 of 20 staff (55%); we saw that there were plans for three staff to complete this. Breakaway training had been completed by 2 of 3 staff (67%); we saw that one person was booked to complete this.
- We reviewed records that confirmed staff supervision and appraisal were completed on a regular basis.
- Shifts were covered with staff of the appropriate grade; however Orion unit used a high number of bank staff who we were told do not always have the right experience.
- Staff were present in the main ward areas throughout our visits.
- Staff knew when and how to report incidents. Learning from incidents and service user feedback was discussed.
- Staff knew what would necessitate a safeguarding referral and followed procedures.
- Ward managers told us they had the authority to increase staffing numbers to meet patient need. On the day of our visit Orion ward had two additional staff on shift to safely address patient needs.

Leadership, morale and staff engagement

- Staff we spoke to said they were happy in their roles but acknowledged at times the job could be stressful.
- Staff told us morale was good and they found their jobs satisfying. One staff member told us 'the staff team are positive and work well together therefore the patients are stable.'
- Staff said they were confident to raise concerns without fear of victimisation.
- Staff were confident and knew the process for whistleblowing.
- Staff told us they felt valued and respected team members.
- We saw evidence that the duty of candour was observed and apologies given when things went wrong.
- Staff had access to team meetings and supervision so that they could give feedback on services.
- Orion unit had a high level of sickness for nine months of the previous year. June 2015 figures were 11.25%, which was an improvement on the previous 3 months. Staff told us that sickness was an issue, bank staff were used to try to fill the gaps. We were told that a number of senior experienced staff had left the unit. There was a new manager in place and we were told things were improving.
- We were told that a number of experienced staff had left. We interviewed two new staff members who had been recruited into the previously vacant posts. Sickness and staff turnover were being managed by the ward and service manager.

Commitment to quality improvement and innovation

- We saw evidence of audits being completed at ward level; clinic room equipment and infection control. One deputy ward manager told us that they were an environmental officer and that they supported the writing of annual reports.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- There were not always sufficient, suitably qualified, competent, skilled and experienced staff to provide a comprehensive service to patients.

18(1)