Requires improvement

Humber NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

298 Cottingham Road
Hull
Humberside
HU6 8QG
Tel: 01482 389216
Website: www.humber.nhs.uk

Date of inspection visit: 11 - 15 April 2015
Date of publication: 10/08/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV915	Townend Court	Willow	HU6 8QG
		Lilac	HU6 8QG
		Beech	HU6 8QG

This report describes our judgement of the quality of care provided within this core service by Humber 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 Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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 8

How we carried out this inspection 8

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 29

Summary of findings

Overall summary

We rated inpatient wards for people with learning disabilities **requires improvement** because:

- Staff did not always identify and assess known risks to the health, safety and welfare of patients and have plans in place to manage these. Where plans were in place, staff did not always review these in response to incidents. Potential environmental risks on some units had not been fully assessed and mitigated.
- Staff did not always follow procedures in relation to possible safeguarding concerns involving patients. Staff had not referred some incidents that met the threshold to the safeguarding team. There was no rationale as to why not.
- Staff did not always log all incidents that met the reporting criteria as set out in trust policy on the trust's incident reporting system. There was inconsistency between incidents that were reported.
- There was a lack of overall review at service level of interventions such as restraint and seclusion. Informal debriefs took place in response to incidents and staff reflected on what could be done differently in future.
- There were shortfalls in some mandatory training compliance and the service had not met the trust target. The areas where fewest staff had undertaken training were the Mental Capacity Act training, safeguarding and equality and diversity.
- There was no clear structure about what additional competencies and skills staff should have in order to support patients with learning disabilities and associated conditions. This included skills and training staff needed to support patients with their mental health.
- Incidents were not being assessed and routinely monitored at management level. This was due to a backlog. Therefore, risks in relation to the service were not being effectively identified and acted upon. This had been an ongoing issue and there was no information as to how this was going to be addressed.
- Care plans did not always reflect patients' holistic needs. In most, it was not clear what treatment plan patients were working towards. There was a lack of clear objectives and goals for recovery and progress towards these. Multi-disciplinary working was not fully embedded as part of patients' treatment and recovery although this was gradually improving.
- Staff used several separate systems to record patient information which meant there was a risk of important information being overlooked.

However:

- Patients and carers spoke highly of the staff and said they were treated with kindness and respect. They said they felt safe, were able to have one to one time with staff and would speak out about any worries or concerns they had.
- Staff involved patients in contributing to their own care plans and carers told us they were involved in these. The units were calm and staff were good at reassuring patients and managing behaviour.
- Staffing had recently improved at the service. Patients were able to have escorted leave and activities as planned. Patients received support with their physical health.
- There were systems in place in relation to admission and discharge planning. The service was proactive in working with other organisations.
- Staff undertook ward based learning and had regular meetings. There had been previous shortfalls in staff receiving supervisions and appraisals but this had improved.
- Senior managers had a clear vision for the future of the service. Staff said managers were very approachable and that the team was supportive.

Summary of findings

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

Are services safe?

Requires improvement

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

- Staff did not always identify and assess known risks to the health, safety and welfare of patients and have plans in place to manage these. Where plans were in place, staff did not always review these in response to incidents. Potential environmental risks on some units had not been fully assessed and mitigated
- Safeguarding concerns were not always recognised by staff and dealt with in accordance with safeguarding procedures.
- Staff did not always review the use of restrictive interventions such as restraint and seclusion to ensure they were proportionate and to ensure that patients were not subject to excessive restrictions.
- Not all incidents that met reporting criteria as set out in trust policy were reported on the trust's incident reporting system. There was inconsistency between incidents that staff reported.
- There were shortfalls in some mandatory training compliance, particularly in relation to Mental Capacity Act training, safeguarding, and equality and diversity.
- The units were not fully compliant with Department of Health guidance on eliminating mixed sex accommodation.
- The service had not met safer staffing levels for the three months preceding our inspection, however staffing levels were improving due to recent recruitment.

However:

- Patients said they were able to have one to one time with staff and access their leave entitlement.
- Vacancies were being actively recruited to and staffing levels had recently improved.
- All patients told us that they felt safe. Staff undertook regular checks of drugs and emergency equipment. Measures were in place to promote infection control and the units were clean. There were checks in place to ensure medicines were managed safely.

Are services effective?

Requires improvement

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

- There was no evidence that all necessary staff had training and skills to support patients with learning disabilities, associated conditions and with their mental health.

Summary of findings

- Care plans were not always reflective of patients' holistic needs, objectives and recovery goals Multi-disciplinary working was not fully embedded as part of patients' treatment and recovery although this was gradually improving.
- Capacity assessments did not always contain a clear documented rationale of how the assessor had reached their decision about a patient's capacity.
- Staff used several separate systems to record patient information which meant there was a risk of important information being overlooked.

However:

- Staff participated in regular ward based learning. Supervisions and appraisals had recently improved and staff felt supported.
- Staff supported patients with their physical health needs. Staff used recognised good practice guidance and outcome measurement tools.

Are services caring?

Good

We rated caring as **good** because:

- Patients and carers spoke highly of the staff and said they were treated with kindness and respect.
- Staff actively involved patients in contributing to their own care plans.
- Patients had access to advocacy services.
- Carers were encouraged to be involved in patients care. Most said that communication was excellent.
- Staff respected patients' privacy and confidentiality.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- There were systems in place to ensure all admissions to the service were necessary.
- Discharge planning started prior to, or upon admission. The service was pro-active in working with other agencies to try to facilitate successful discharge.
- Patients knew how to make complaints and were confident in staffs' ability to resolve any, although information was not openly on display about how to complain.
- The service could accommodate diverse needs of patients and provided a range of activities seven days a week.

Are services well-led?

Requires improvement

We rated well led as **requires improvement** because:

Summary of findings

- Due to a backlog, incidents were not being assessed and routinely monitored at management level. Therefore, risks in relation to the service were not being effectively identified and acted upon. This had been an ongoing issue and there was a lack of progress as to how this was to be addressed.
- Outstanding actions at service level were not always followed up in order to identify areas for improvement.
- The service had no set plan of what training staff were required to have to ensure they were equipped for their roles.
- There were no current key performance indicators in place in order to measure service performance however, the service was looking to develop these.

However:

- Staff felt supported and spoke positively about the senior management team.
- The senior management team had a clear vision for the service with recognition of where improvements were needed.
- Team morale was good.
- The service participated in a nationally recognised improvement scheme.

Summary of findings

Information about the service

We rated well led as **requires improvement** because:

- Due to a backlog, incidents were not being assessed and routinely monitored at management level. Therefore, risks in relation to the service were not being effectively identified and acted upon. This had been an ongoing issue and there was a lack of progress as to how this was to be addressed.
- Outstanding actions at service level were not always followed up in order to identify areas for improvement.
- The service had no set plan of what training staff were required to have to ensure they were equipped for their roles.
- There were no current key performance indicators in place in order to measure service performance however, the service was looking to develop these.

However:

- Staff felt supported and spoke positively about the senior management team.
- The senior management team had a clear vision for the service with recognition of where improvements were needed.
- Team morale was good.
- The service participated in a nationally recognised improvement scheme.

Our inspection team

Chair: Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of inspection: Jenny Wilkes, Care Quality Commission.

Team Leader: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission.

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team that inspected wards for people with learning disabilities consisted of an inspector, an inspection manager, a specialist advisor who was a clinical psychologist, a Mental Health Act reviewer, a pharmacist and an expert by experience. An expert by experience is someone who has direct experience of using, or caring for people using, the type of service being inspected.

Why we carried out this inspection

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

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 these services, asked a range of other organisations for information and sought feedback from patients and carers at two focus groups prior to the inspection visit.

During the inspection visit, the inspection team:

Summary of findings

- visited all three units at the hospital site Townend Court. These units were named Willow, Lilac and Beech. We looked at the quality of the environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with six carers and relatives of patients using the service
- collected feedback from three patients and carers using comment cards
- spoke with an independent advocate who supported several patients using the service
- spoke with the service manager, modern matron, unit manager and deputy managers for the units
- spoke with seventeen other staff members including doctors, nurses, healthcare assistants, an occupational therapist and psychologists
- spoke with the clinical care director with responsibility for these services
- observed one multi-disciplinary meeting, one pre admission meeting, a weekly admissions panel meeting and a patients' 'talk together' group
- looked at nine patients care records and prescription charts for all 14 patients
- carried out a check of the medication management on each unit
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with patients and carers at two focus groups prior to our inspection. We also spoke with patient and carers individually during our inspection visits.

All patients were very positive about how staff cared for them. Patients contributed to their own care plans. They said there were enough staff to support them. They were able to have one to one time with a staff member and take part in activities. Patients said staff provided them with information about the service. All said they felt safe and would tell a staff member or advocate if they had a complaint. Some patients said doctors did not always listen to them.

Carers spoke highly of the staff and described them as warm and caring. The majority said communication was excellent. However, one said it was poor amongst some staff. Carers were involved in care planning and reviews of care. Most carers were very pleased with the support their family member received. Two carers felt their family members' support did not always meet their needs.

We received comment cards from two patients and a carer during the inspection. One person also called our contact centre to give their view of the service. All feedback was complimentary about the staff and the service.

Good practice

Several patients had tablet computers provided by the trust. These incorporated an application (app) called 'my health guide app'. This app had come from an original concept commissioned byHumber NHS Trust. It had been adapted for use in the learning disability services. One of the deputy managers at Townend Court had worked with the developers on the app.

The app helped patients to own their information and take a role in their own health care. Patients could customise the app so that it was personal to them. Information could be recorded in a number of ways such as text, audio, video and images. The app also allowed professionals, with the patient's agreement, to add content that could help in understanding and reinforcing professional advice.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all known risks to patients are assessed and there is a plan in place as to how these should be managed safely. This should include all environmental risks. Staff should review and adapt these as necessary.
- The provider must ensure that the management of behaviour that challenges is a proportionate response to the behaviour and in accordance with least restrictive principles. The provider should have an effective way of monitoring this.
- The provider must ensure that all ward staff are able to recognise and act upon safeguarding concerns and take necessary action. They should ensure safeguarding procedures and policies are followed.
- The provider must ensure that care plans are sufficiently detailed, reflective of patients' needs, holistic and recovery focussed.
- The provider must ensure that all relevant staff have the necessary skills, training and competencies required in order to perform their roles. This should include the skills to support patients with learning disabilities and associated conditions. Staff should have their skills updated as necessary.
- The provider must ensure that all reportable incidents are reported on the trust incident reporting system as required. Staff must be clear about what to report.
- The provider must have an effective system in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients at service level. This should include monitoring of incidents in a timely manner and having systems to learn from these.

Action the provider SHOULD take to improve

- The provider should continue to embed and improve positive behaviour support planning and review the effectiveness of these for individual patients.
- The provider should continue to develop the service model and continue work towards a more multidisciplinary approach for the benefit of patients' recovery.
- The provider should ensure that capacity assessments contain a clear documented rationale of how the assessor has reached their decision.
- The provider should review how patient information is stored to ensure information is easily accessible and risks of information being missed are minimised
- The provider should review how the service and environment is able to adhere to Department of Health guidance on eliminating mixed sex accommodation effectively.
- The provider should identify and develop service specific key performance indicators that can be used to measure and drive improvement.
- The provider should ensure that all staff have the necessary training to work in accordance with their responsibilities under the Mental Health Act 2007 and in line with the current code of practice.

Humber 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
Willow Lilac Beech	Townend Court

Mental Health Act responsibilities

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

The trust had an Mental Health Acts administrator who scrutinised documents. Detention documentation was easy to locate and clearly filed.

Twenty three members of staff had completed Mental Health Act training, which incorporated the updated Mental Health Act Code of Practice. This training was not mandatory for staff.

Staff verbally informed patients of their rights on a regular basis. Information about their rights was available in easy read format to aid understanding. Patients were aware of their legal status and rights. There was a system in place to ensure patients were referred to an independent mental health advocate where they met the criteria.

Completed consent to treatment authorisation forms were located with prescription charts. Staff made referrals to second opinion appointed doctors appropriately.

There was a standardised process for authorising section 17 leave and leave forms were written clearly. However, we found that old copies of section 17 leave forms were not all struck out. This issue was also identified at a mental health act review visit in 2015.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act 2005 training was mandatory. However only 32 out of 55 staff, which equated to 58%, had completed this. Despite this, staff we spoke with demonstrated a good understanding of the Act. There was guidance about the Act that staff could access.

No patients at the service had a current Deprivation of Liberty Safeguards authorisation in place. The service had applied for these in the past and most staff could explain in what circumstances they would apply. Some staff were not as clear, which suggested differences in staff understanding around Deprivation of Liberty Safeguards.

There were policies in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards that staff could access. Staff told us they knew where to find this as well as further information and guidance.

We saw mixed practice in relation to capacity assessments. There was evidence in records that staff had the considered and applied the Mental Capacity Act as necessary in relation to specific decisions. However, some capacity assessments did not fully demonstrate how the decision about patients' capacity had been reached. The decision making process was not robust.

Requires improvement

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

Willow and Lilac units were purpose built. The open layout meant staff could observe patients easily. Beech had been redesigned from an existing building and the layout did not allow for clear lines of sight. There were no mirrors to offer further viewing capability. Some patients on the unit had behaviours that challenged including acts of aggression and self-harm. The restrictions in observing the patients meant there was a risk of incidents going unnoticed which could lead to a delay in assistance. Staff told us they would they use their professional judgement if they felt people required extra monitoring.

Ligature point audits were last completed in March 2016. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The mitigation for most identified ligature points was that the area they were in was locked, and staff would supervise patients. For other risks where this did not apply, staff assessed patients individually in accordance with the risk. For example, if patients had demonstrated, or had a history of suicidal ideation, they would increase observations.

The service only had one seclusion room and this was situated on Willow. The seclusion room, ensuite and adjoining lounge were not assessed as part of the latest ligature audit. The reason stated was that the room was in use at the time. We saw a potential ligature risk when the adjoining ensuite door was secured in the open position. This appeared to create a possible anchor point above the door. The previous audit from May 2015 had recorded no concerns with the seclusion area. Therefore we saw no evidence that all potential risks had been identified and assessed.

The viewing panel in the seclusion room was heavily scratched which prevented staff having a clear view through. There was no clock on display which patients could see from the room. This was not in accordance with the Mental Health Act Code of Practice guidance, which states patients should be able to see a clock at all times. Staff could adjust the temperature externally and there was facility for two-way communication. We looked through the viewing panel of the adjoining ensuite and saw a blind spot near the sink area. There was no mirror in place to address this. This meant the room could not be fully observed to ensure patients safety when in use.

The units were not fully compliant with Department of Health guidance on mixed sex accommodation. Beech had no facility for separate male and female sleeping areas. All bedrooms were situated along one corridor. There were no females on the unit during our inspection. A senior staff member said they would not currently accommodate females on Beech as it was not compliant with mixed sex accommodation. However, some other staff told us females would be located in bedrooms at the end of the corridor to sleep.

Willow and Lilac each had designated male and female corridors. There were two lounges on each unit. Staff said they were able to use one of these as female only but neither were being used as such at the time of our inspection. On Willow there were two males and one female patient. The two male patients each slept on one of the corridors. This meant the female patient's bedroom was on the same corridor as a male patient. The trust's dignity and privacy policy stated that where it was necessary to admit an individual to a sleeping area of the opposite sex, a risk assessment and care plan should be completed and action taken to rectify the situation as soon as possible. Staff had not completed a risk assessment or care plan for the female patient regarding this situation.

The clinic rooms on each unit were clean and tidy. Resuscitation equipment and emergency drugs were present. Staff checked these regularly and recorded their findings. On Lilac, there was no calibration sticker on the blood pressure monitor to confirm when it was last checked. As such, the monitor could not be guaranteed to give accurate readings.

Domestic staff were present cleaning the units during our inspection. Patients said they worked very hard. They said the units were very clean and domestic staff helped them keep their rooms tidy. There were cleaning schedules in place to ensure all units were cleaned regularly.

Requires improvement

Are services safe?

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

In the patient-led assessments of the care environment (PLACE) survey for 2015, Townend Court scored 100% for cleanliness and 95% for condition, appearance and maintenance.

There was an infection control policy in place. We saw staff adhered to handwashing procedures and antibacterial gel was available on entry to the units. The modern matron and unit manager carried out regular environmental audits including infection control, health and safety and fire safety.

Furniture, décor and equipment was generally well maintained but we noted some areas in need of repair. The assisted bath on Lilac was out of use. The door handle to the female corridor on Willow was missing. An area on the wall outside the seclusion room was damaged. The notice board on Willow was missing its protective cover. Staff were aware of these issues and told us all had been reported for repair.

There were call buttons in toilets and bathrooms so patients and staff could summon assistance quickly if needed. If a patient required assistance in their own room, for example if they had limited mobility, then they could have an alarm to alert staff. Staff said they had done this in the past where patients required. Staff carried personal alarms.

Safe staffing

Bank staff were used to fill gaps in staffing. The service tried to use the same regular bank workers so they were familiar to the patients. This also helped maintain consistency of care. The service did not use agency workers. Planned and actual staffing levels were on display in reception and outside each unit. There were qualified nursing staff on each unit. The managers told us staffing was reviewed constantly to ensure the correct mix of staff was in place to meet patients' needs. Extra staff were brought in where patient need demanded.

A safer staffing report from March 2016 showed Townend Court had not met safer staffing levels for the preceding three months. A shortage of nurses at night was the main concern. The service operated on twelve hour day and night shifts. Rotas for the six weeks prior to our visit showed all shifts, except Beech night shift, had a minimum of one registered learning disability nurse on duty alongside health care assistants. Beech operated with two healthcare assistants at night. The staffing report said a review of the staffing levels had resulted in a reduction of nurses at night. The amount had gone from three nurses to two. The review said this was due to the function of Beech as a rehabilitation service. The rationale was that clinical need for patients at night would be less than on the other units. Several staff we spoke with said nurses did sometimes work on Beech at night. Managers said if a situation arose where a nurse was required on Beech then one from another unit could assist. There was also an on-call nurse arrangement in place.

There were ten incident reports from the previous 12 months highlighting unsafe staffing levels. The most recent was from February 2016 where Beech had operated with one member of staff at night. The service had recently recruited five nurses and advertisements were out for six further health care assistants. The unit manager said this would take the service to its full complement of nursing staff and help to resolve staffing issues and ensure appropriate skill mix was available.

Patients told us they always had one to one time with a member of staff. All except one of the patients we spoke with told us there were 'a lot' and 'plenty' of staff. One patient said that at times there were not enough, as other patients needed extra support, which then took staff away. They said they understood this was for safety reasons. Carers told us there were always enough staff present when they visited.

Section 17 of the Mental Health Act allows the responsible clinician for a detained patient to grant them legal leave of absence from hospital. It is an important part of a patient's recovery. Two patients said in the past there had been times when their section 17 leave did not take place due to lack of staff. They told us this did not occur now additional staff had been recruited. Other patients said they regularly had leave as planned. Staff said they were able to facilitate leave. We saw a number of patients take escorted leave. This showed that staffing levels did not prevent patients having their leave entitlement. Patients told us there were activities available each day. Scheduled activities all took place as planned during our inspection.

Medical cover was available on site during the day Monday until Friday and some weekends. When medics were not on site, there was an on call system in place. Staff told us medical assistance was available in a timely manner with no undue delays. The consultant psychiatrist confirmed the

arrangements in place for medical cover. He said when doctors were on call they were able to respond quickly in the event of an emergency as they either lived, or stayed over in the vicinity.

Staff were not up to date with all mandatory training. The trust had a target of 75% compliance. The current compliance rate for the service up until March 2016 was 72%. The subjects with the worst compliance rates were; equality and diversity at 49%, Mental Capacity Act at 58% and adult safeguarding at 65%.

Assessing and managing risk to patients and staff

At our inspection in August 2014, we found the service's risk assessment tool, called the Galatean risk and safety tool, was not learning disability specific. The version being used at that time was the Galatean risk and safety tool for older adults. The trust sent an improvement plan to say they would adapt the tool so it was applicable to learning disabilities. The plan stated the new tool would be reviewed in March 2016. At this inspection, we found the new assessment tool had not been fully implemented. Most staff told us they still used the previous older adults' version. No review of the adapted tool had taken place.

Risk assessments had not taken into account all known risks for patients. We looked at the care records for nine patients. In three, we found evidence of where staff had not assessed known risks to patients. For example, one patient's history included behaviours of violence and self-harm. Five recent entries in the patient's records showed they had either expressed a wish to self-harm, had self-harmed and had damaged property. The patient had reported hearing voices and on one occasion told staff they had tied a ligature around their neck. The patient had a care plan for the management of behavioural distress dated November 2015. This did not refer to self-harm, violence or hearing voices. This had not been reviewed in response to the episodes of challenging behaviour. Although staff managed the incidents individually at the time, there was no overall information about how the behaviour and risk should be mitigated. National Institute for Health and Care Excellence guidance for 'challenging behaviour and learning disabilities' states that staff should assess and regularly review notable areas of challenging behaviour including suicidal ideation, self-harm and harm to others.

There was no initial Galatean risk and safety tool assessment for one patient. This should have been completed on admission. Two members of staff confirmed they would expect this to be present but were unable to locate this.

We also saw good information of where patients had initial risk assessments completed. There were behaviour management plans for each patient. These included where the patient's behaviour may escalate and provided guidance about what action staff should take in response to the patient's behaviour. There was evidence patients had been involved with compiling these.

Staff told us that they discussed patients' risks in multidisciplinary meetings including any incidents of challenging behaviour. However, the failure to identify, assess and have plans in place for management of known risks put patients at risk of unsafe care.

The units were locked and staff allowed entry and exit to patients. Both informal patients were aware of their status and right to leave. Staff were also aware of the rights of the informal patients and we saw the door was unlocked at their request.

One staff member said all patients had to be supervised by staff when they used the assisted bathroom because of ligature risks. Others said patients could use the assisted bathroom unsupervised unless there was any known risk involved. This demonstrated inconsistency as to when patients required supervision, which could subject them to unnecessary restrictions. No searching of patients was undertaken. There were policies in place setting out when this would be undertaken and in what circumstances.

The unit manager and staff understood the supportive engagement policy and the importance of meaningful contact with patients. They told us this was something they did routinely at the service. Patients who needed increased observations had staff present to facilitate this. Nursing staff used their clinical judgement as to what observations patients required.

Current Department of Health guidance titled 'positive and proactive care' states; 'staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface'. Trust data for the six months prior to our inspection showed 25 uses of restraint and nine episodes of seclusion

Requires improvement

Are services safe?

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

on Willow. On Lilac, there were seven uses of restraint and two episodes of seclusion. The trust did not supply figures for Beech. It was reported that none of these resulted in the use of prone (face down) restraint or rapid tranquilisation.

Staff received training in the management of actual or potential aggression. This was updated annually. Staff told us they used restraint as a last option and did not use prone restraint. However, incident reports showed there had been three instances of prone restraint in February 2016. One of these lasted over 45 minutes. This contradicted what staff told us about not using prone restraint. The use of this type restraint, especially for significant periods, meant patients' health and safety had been put at serious risk of harm.

We looked at six seclusion records. The Mental Health Act code of practice states that seclusion should end when it is no longer warranted. The entries we saw indicated that seclusion

continued in excess of when it was required. For example, several entries stated the patient was settled, calm, or not in distress but the outcome of the review was to continue seclusion.

The trust management of violence of aggression policy said a documented record of post incident reviews of physical intervention should be completed and shared as necessary. The use of seclusion and restraint was an agenda item on the unit managers' weekly meetings. One action was to produce details of episodes of seclusions and restraints, however no reports had been produced. There was no evidence of any other formal review of these episodes. Therefore, we could not be confident that patients had not been subject to excessive restrictions and that the interventions used were proportionate.

Staff told us rapid tranquilisation was used rarely and only as a last resort. We saw no recent instances of when this had taken place. Staff were aware of the policy for rapid tranquilisation and the need for physical health checks following this.

Patients' welcome packs included information about abuse written in easy read format. It told patients what abuse consisted of and what to do if they were being abused. Patients told us they would alert staff of any abuse. No patients had a current protection plan in place. The manager said where a patient had one, the plan would be recorded in care records and staff made aware.

Nineteen out of 55 staff had not completed, or were not up to date with, safeguarding adults training. Despite this low compliance to safeguarding training, staff said they were clear about safeguarding and the procedures to follow including how to make referrals. The safeguarding policy said referrals should be made when abuse occurred or was alleged. It stated the rationale for not making a referral that met the criteria should be fully documented to show this had been considered. We saw evidence of referrals made by staff in accordance with this. They had documented details of contact with the safeguarding team along with their response and advice.

However, there were instances where staff had not followed these procedures. Records showed one patient had told staff another patient had threatened them into giving up some of their belongings. This had not been referred to the safeguarding team and there was no information to show this had been considered. There were documented occasions of patients causing harm and minor injury to other patients. Although staff had taken action in response to these, there was no evidence of any safeguarding considerations. Another patient's relative alleged somebody (unrelated to the service) had recently taken money from the patient whilst on leave. Staff had not taken any action at the time the allegation was made to follow this up. This showed that staff had failed to identify and take appropriate action to respond to safeguarding concerns. This had exposed patients to risk of harm and abuse.

We looked at the systems in place for medicines management and assessed fourteen patients' prescription records. We spoke with nursing staff, and the pharmacist, who were responsible for medicines. Medicines were stored securely with access restricted to authorised staff. There were appropriate arrangements for the management of controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. Medicines requiring refrigeration were stored appropriately and staff monitored temperatures in accordance with national guidance.

Administration records were completed fully; people received their medicines as they had been prescribed and in accordance with the Mental Health Act. Patients did not have any concerns with how their medicines were managed.

Requires improvement

Are services safe?

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

Children were not permitted onto the units to visit patients but were able to visit in the premises. There was a visitors policy which included guidance for children visiting services. Safeguarding children was mandatory training for staff.

Track record on safety

There had been one serious incident at the service in September 2015 that involved two patients. Staff had reported this and it had been dealt with in accordance with the serious incident policy. An investigation took place and there was an action plan resulting from this. Actions included training for staff in 'lessons learned' from the investigation via ward based learning. Relevant policies and staffing levels had been reviewed following the incident. This showed the investigation had sought to identify where improvements could be made to the service and to help prevent recurrence.

Managers updated families of the patients involved about the progress of the investigation and completion of the action plan. A relative of a patient who was involved told us they were kept informed 'every step of the way'. This showed the incident had been dealt with openly and in a transparent manner.

Reporting incidents and learning from when things go wrong

Staff reported incidents on the trusts' electronic incident reporting system called Datix. Staff knew how to make reports although we found inconsistencies and omissions in what they reported. For example, the privacy and dignity policy said any breaches of mixed sex accommodation, should be reported on Datix. No incident report had had been submitted in relation to the breach on Willow or any other breaches of this nature.

The trust's management of violence and aggressive behaviour policy said incidents of challenging behaviour, violence and aggression, physical or non-physical, and near misses to incidents should be reported. The care records of two patients contained several incidents that included self-harm, and aggressive and violent behaviour. Staff had not reported all of these on Datix. There was no rationale of why some incidents were reported yet others of the same nature had not. The service manager and modern matron said they were intending to provide Datix reporting training to staff so they were clear about what they needed to report.

Patients and carers told us staff were open and told them with things went wrong. One carer said staff informed families when medication errors had taken place. They were confident in the staff's' honesty to tell them about any mistakes. During our inspection, a staff member found that a newly admitted patient had arrived with incorrect medication from the service they had come from. The staff member informed the patient, their relatives and passed information on to staff. They were going to report this as an incident and arranged for the patient to get their correct medicines.

Managers and staff said they discussed feedback from incidents in team meetings and supervisions. Minutes of the latest team meetings we saw did not include discussions about incidents and it was not a standard item on the agenda. Weekly managers' meetings minutes showed that review of outstanding Datix reports was an ongoing concern for the service as well as at trust level. The service was not up to date with the reports and this was still an ongoing issue at the time of our inspection. The service manager and modern matron told us that as reports came to them directly they were able to triage them in terms of urgency. However, further reviews to look for themes and trends were not being routinely undertaken which meant that learning from incidents was not always captured.

Staff said debriefs were almost an automatic process following incidents. They would immediately have an informal discussion and reflect about what they could do differently or better if the same thing happened again. If further in depth debriefs were required, these could take place.

Are services effective?

Requires improvement

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

We saw examples of comprehensive assessments in care records that staff completed on admission. Patients received a physical examination and told us staff discussed their health needs as part of the care planning process. We saw evidence of health action plans in some patients records although these were not present in all. Health action plans are good practice documents for people with learning disabilities. They contain information personal to each person about what they need to do to stay healthy. The manager told us these were ongoing and some patients had said they did not want these in place.

We saw evidence of patients' involvement in their care plans where they had chosen to contribute to these. Care plans were written in easy read format and were person centred. However, we found the information present did not provide a holistic view of the patient. Care plans did not cover all aspects of patients' care needs, or provide sufficient detail in some cases. For example, staff told us about one patient who made unwise choices at times in relation to their finances. The patient had a capacity assessment in place where they were shown to have capacity. There was no information present about what support the patient needed in relation to their finances. Patients' individual objectives and recovery-oriented goals were lacking. This meant it was not always clear to see what outcomes patients were working towards, how they were going to achieve these and what progress patients had made. Although staff knew patients and their needs well, this information was not always captured within their records. One carer told us they felt staff were not providing support in all areas their family member needed. Information from a relative in another patient's records stated they did not feel staff were fully aware of the patient's needs and risks. Other carers were very pleased with the support their family members received.

Staff understood the principles of positive behaviour management but there appeared to be a disjointed approach. Patients had behaviour management plans that provided information to staff about how they should positively manage behaviour. This was the main plan that nursing staff completed and referred to. Besides these, we saw positive behaviour support plans in some patients' care and treatment review files. Where positive behaviour support plans were present, the psychologist had completed these. These were recent and there had been no monitoring of their effectiveness. Staff spoke of the documents separately and made distinctions of psychology taking the lead for positive behaviour support plans. The lack of joint assessments and understanding meant there was a risk patients could receive inconsistent care.

Patient information was stored in several different ways, both electronically and in document format. The two electronic systems were called Systemone and Lorenzo. Staff also used a computer network drive to store patient information. Doctors wrote clinical notes in paper records. These were kept in a hard copy file with a variety of assessments. Each patient also had a hard copy care and treatment file which included care plans, risk assessments and behaviour management plans.

We found it difficult in some cases to locate specific information whilst looking at patients' records. Several staff also raised concerns around information being stored in different locations, as well as the time it took to find information. At our inspection in 2014, the matter of clinical notes being recorded separately to electronic records had been raised as an issue. The trust responded to state all staff would receive training in Systemone. However all staff were still not using Systemone. As patient information was not held centrally in one place, there was an increased risk that information may be overlooked. Lack of electronic notes and a single care plan record for patients was on the trust risk register as a trust wide risk.

Best practice in treatment and care

Medication administration was undertaken appropriately and a pharmacist had input at the service. However, we saw one example of a medicine being used for an unlicensed indication. This meant the medicine was being used outside of what it should be prescribed for in accordance with its licence. There are clinical situations when the use of unlicensed medicines may be judged by the prescriber to be in the best interest of the patient. However, there was no acknowledgment and risk assessment in the patient's care plan to ensure it was safe to do so in this case.

Patients had access to psychological therapies. Two psychologists were part of the staff team who worked across the units. There were vacancies for two more.

Are services effective?

Requires improvement

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.

Psychologists told us they were keen to help implement psychological therapies as a fundamental part of patients' recovery. The consultant psychiatrist said they would like access to more psychology for patients. Senior managers recognised the importance of psychology as a treatment. The service was working towards improving and embedding this.

Patients had access to specialist services in respect of their physical health. There was evidence in care records of on-going health monitoring. Patients had care plans for keeping well and healthy. Staff supported patients to maintain their health and manage any medical conditions they had. There was input from occupational therapy and speech and language therapy. Nutritional assessments were included in patient's initial assessment.

Staff used recognised rating scales to assess and record severity and outcomes. These included psychiatric assessment schedules for adults with developmental disabilities and Health of the Nation Outcomes Scales amongst others. Staff completed rating scales regularly and recorded scores in patients care records. Staff said these were routinely reviewed at multidisciplinary meetings. However, it was not clear how the ratings influenced care provision and fed into care plans.

Skilled staff to deliver care

The staff team was made up of a range of professionals. This included; learning disability nurses, psychiatrists, psychologists, activities workers, occupational therapist, speech and language therapist and healthcare assistants. There was regular input from a pharmacist employed by the trust who attended regularly. Other staff members not involved in direct care but important to operation of the units included the administrator, receptionists, housekeeping and domestic staff.

There were several patients using the service who displayed behaviour that challenged. Current National Institute for Health and Care Excellence guidance for 'challenging behaviour and learning disabilities' states that providers should ensure staff supporting people with behaviour that challenges have the training and supervision needed to ensure that they have the necessary skills and competencies.

A recent induction program had been designed and implemented in January 2016 for a cohort of ten new healthcare assistants. The program included learning topics in areas such as epilepsy, autism and positive behaviour support planning. Staff who had been on the induction said it was very informative. Staff also had the opportunity to undertake ward based learning. This was delivered approximately every two months and covered a range of subjects.

Although staff had in house learning opportunities, there was no plan of what training all staff required to ensure they were equipped with the necessary skills to meet the needs of the patients. Individual staff training records showed some members of staff had completed additional specialist training. They also showed some staff had not received any training outside of mandatory subjects. There was no set structure as to what staff groups required what training and how often this should be updated. This meant there was a risk staff may not have the necessary skills required to effectively support patients using the service.

Managers told us supervisions had not always taken place in the past as planned but this was getting better. They said recruitment of staff and setting up Beech had contributed to this. Supervision records for 2016 showed the majority of staff had, and were receiving, regular supervisions. Staff told us they had regular clinical and management supervisions.

The trust target for compliance with appraisals was 85%. Appraisal rates for Willow and Lilac were 88% and 82% respectively. Beech was 54%, however this unit had only been in operation several months. Regular staff meetings took place. Staff told us they felt supported by their manager and colleagues on the ward. They said they worked well as a team and could rely on each other.

Multi-disciplinary and inter-agency team work

Multidisciplinary meetings occurred weekly and patients were able to attend these if they wished. We attended one meeting with permission from the attendees. One patient chose to attend when it was time for their review. One patient's relative also attended for the discussions about their family member. A range of professionals attended the meeting. There was a primarily clinical focus to the meeting we attended. However we did note that staff discussed other areas of patients' needs, such as social and psychological interventions.

Handovers took place at each shift change. We did not observe a handover but looked at the handover documentation completed for one shift. There was

Are services effective?

Requires improvement

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.

information recorded about every patient and how they had presented during the previous shift. Staff said they were kept up to date about information they needed to know in order to provide consistent care.

The manager said the service had a good working relationship with other organisations both internal and external. This included the community learning disability team with whom they worked closest. Members of the community team attended weekly panel meetings. The service manager and modern matron also had responsibility for the community team, which were also based at Townend Court.

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

The Mental Health Act reviewer reviewed nine detention documents for the detained patients and six seclusion records.

The trust had an Mental Health Act administrator who scrutinised documents. Documentation was easy to locate and clearly filed. Detention documentation appeared in order. A system was in place to ensure timescales were met in relation to renewals, tribunal referrals and requests for second opinion appointed doctors.

Mental Health Act training was not mandatory. Twenty three out of 55 members of staff had completed Mental Health Act training with further sessions planned. The training included the most recent changes to the Code of Practice. Most staff we spoke with had a good understanding of the Mental Health Act. One staff member felt there should be more training in this area. There was a risk that without suitable training staff may not work in accordance with current Mental Health Act guidance.

Completed consent to treatment authorisation forms were located with prescription charts. Staff made referrals to second opinion appointed doctors appropriately. There was no discrepancy between medications staff administered and medications authorised by the second opinion appointed doctors. However, we could not see how the responsible clinician had recorded how the decision was reached about the patient's capacity to consent to medication. In some records, we found the four stage capacity questions had a yes or no next to them with no detail about how that decision was reached.

Staff verbally informed patients of their rights on a regular basis and recorded the outcome on each occasion. We saw staff could provide this information in easy read format also. This included a record of the patient response and their understanding. There was an independent mental health advocacy service available to all patients. Information about the advocacy service was displayed on all wards. The hospital had a system to refer patients who lacked capacity to this service.

There was a standardised process in place for authorising section 17 leave. Section 17 leave forms were clearly written. Risk assessments took place before leave was agreed. During the inspection, we found that old copies of section 17 leave forms were not all struck out. We had also identified this issue during a mental health act review visit in October 2015. The action plan we received in relation to this was that regular section 17 audits would be undertaken. These had failed to identify this issue.

The units had locked doors and staff were unclear how this was reviewed. There was no evidence that the impact of the locked doors had been considered for individual patients in accordance with the Code of Practice. The trust had not recorded why they were not following the Code of Practice guidance regarding the lack of dedicated female only lounges on Willow and Lilac, which both had male and female patients.

The seclusion policy had been updated in February 2016. We found staff were not following the new policy. The policy stated two "suitably skilled professionals" should complete seclusion nursing reviews. We saw that health care assistants were undertaking this role. It was not clear they had training to do this. In some cases only one professional was undertaking a review. We found reviews by the medical staff were often late. There were no exit plans and limited evidence of care plans during seclusion.

Good practice in applying the Mental Capacity Act

No patients had a Deprivation of Liberty authorisation in place at the time of our inspection. Four DoLS applications had been made within the last 12 months. This showed staff were aware of, and knew how to apply for, such authorisations where these were deemed appropriate.

Mental Capacity Act 2005 training was mandatory although only 32 out of 55 members of staff, which equated to 58%,

Are services effective?

Requires improvement

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.

had completed this. However, staff were able to describe the processes and principles in accordance with the legislation. They were able to describe the presumption of capacity and the steps to take to aid decision making.

There were policies available for the Mental Capacity Act and Deprivation of Liberty safeguards legislation which staff were aware of and which they could access for advice and guidance.

We saw varying practice in relation to capacity assessments. Some records showed that staff had applied the Mental Capacity Act appropriately in areas where they needed to take it into consideration. For example, where decisions pertained to detained patients' physical health that were not eligible for consideration under the Mental Health Act. However, some capacity assessments provided little detail about how the outcome had been determined. As such, we could not be satisfied that the Mental Capacity Act was being applied robustly in all instances where it applied.

Patients told us staff always asked their consent. We observed staff asking patients' consent and encouraging them to make their own decisions.

Good

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

Interactions between staff and patients were very positive. Staff spoke in a kind, respectful way and tailored their communication styles to meet the needs of each patient. Two patients had limited verbal communication and were receptive to sensory stimulation. We saw staff used touch, such as holding the patient's hand, in an appropriate manner whilst communicating. We observed one staff member used signing to communicate with one patient who responded in turn with signs and was smiling and laughing throughout the exchange. Some patients had communication passports in place. These helped provide information for staff about how to communicate effectively with patients. The speech and language therapist was in the process of compiling these.

Staff respected confidentiality and spoke with patients in private about any personal issues. They ensured they did not discuss information about patients openly. We saw staff provided emotional support and reassured patients if they became upset or distressed.

Patient and carers spoke highly about the care they received from staff who they described as very warm and caring. They said staff treated them with kindness and respect and there was a friendly atmosphere. They told us staff would help them and were good at listening and offering support. All said that staff respected their privacy and described examples of this such as staff knocking on their doors before entering their rooms.

Patients also said the staff team was consistent and did not change. Each staff member we spoke with had a good understanding of the needs of each patient and their likes and dislikes. Patients knew the staff that were supporting them and were able to name them.

The 2015 patient-led assessments of the care environment score for Townend Court for privacy, dignity and wellbeing was 96%, which was above the national average of 86%.

During a focus group held prior to our visit, some patients said the doctors did not listen to them. One patient said they felt the doctors did not communicate in a respectful way at times as it was in a manner they were unable to understand. During our inspection, one patient said professionals spoke in 'nurse language' in multidisciplinary meetings. They said a staff member would speak with them afterwards to explain things in a way they understood.

One relative said Townend Court was not like a hospital and it was very calm and relaxed. We observed that the units were settled and calm throughout our inspection. Staff were good at managing to de-escalate any behaviour with minimal disruption.

The involvement of people in the care that they receive

Patients received a welcome pack on admission to the ward. We saw these in patients' rooms where we had been invited in. These were available in easy read format and provided information to orient patients to the units.

Patients had opportunity to be involved in decisions about their care. They were involved in compiling their own care plans and two patients showed theirs to us. Information within these was compiled in an easy read format and included information such as their likes, dislikes, what was important to them and how they communicated. Patients were encouraged to attend meetings and reviews so they could influence their care.

Patients told us where they had advocates in place and knew how to make contact with them. We spoke with an independent mental health advocate who supported some of the patients at the service. They said staff were proactive at making referrals for advocacy on behalf of patients. The advocate attended the units at least weekly and was available to provide support to patients including attending multidisciplinary meetings. The advocate said the staff were caring and respectful and made a real effort to get to know the patients.

Carers had the opportunity to be involved in patients care. One patient's relative attended a multi disciplinary meeting we observed. Care records showed involvement with patients family members. At the focus group, some carers told us staff listened to them and adapted how they cared for their relative based on information they gave. The majority of relatives and carers said communication was excellent although one said it was poor amongst some staff. Most said their views were taken into account and they were fully involved with care plans and reviews where appropriate.

Good

Are services caring?

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

There were opportunities for patients to discuss the service and give feedback. We attended a patients 'talk together' group during our visit. Other meetings included quality circle meetings that involved the cook and housekeeping team, coffee mornings, daily activity meetings and 'you said we did meetings'. Minutes of meetings were available in easy read format.

There were opportunities for patients to help influence how the service ran. One patient had a certificate on display from March 2016 commending them for their contribution for interviewing psychologists and speech and language therapists who had recently applied to work at the service. The patient told us they had enjoyed being involved with recruitment of staff. Staff said patients were encouraged to assist in opportunities such as these when they arose.

There was information within patient's care records to record if patients had any advance decisions in place.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The unit manager told us that admissions were mainly planned. There was an admission process for staff to follow. There had been some recent instances where patients were admitted to the service in an emergency.

We attended a weekly admission panel and a pre admission meeting. These were made up of members of the multidisciplinary team and community team. There was discussion about new referrals and discharges and what support patients needed. The pre-admission meeting was held in respect of one patient who was being admitted the next day. The unit manager told us this was the first meeting of this type but it was designed to become regular for new admissions. The purpose was to ensure that admission was absolutely necessary and there were no other more suitable alternatives.

On return from leave, patients always had a bed available. Guidance from the Royal College of Psychiatrists for inpatient mental health wards states that a bed occupancy rate of 85% is seen as optimal. Occupancy levels from September 2015 until 29 February 2016 for Willow was 84%, Beech (opened in December 2015) was 74% and Lilac was 63%. These figures were within the optimal range.

The pathway through the service was assessment, treatment and rehabilitation via Willow, Lilac and Beech. The managers and staff told us patients moved between units in accordance with their needs at the time. We saw examples where patients had spent time on other units. Staff said any moves would be based on clinical need. They would take account of the unit and environment best suited for the patient. Staff told us if people required more intensive or acute care then there were other services in the trust they could access.

Townend Court had the highest increase within the trust for average length of stay. The figures were taken from the previous 12 months. The average lengths of stay of current patients was compared with the average lengths of stay of discharged patients. Lilac's current length of stay had increased from 121 days to 276 days. Willow had increased from 52 days to 196 days. Beech had only been operational since December 2015 but the current figure was 57 days compared to 8 days for discharged patients. There were no out of area placements reported during the period from 1 June 2015 up to 31 March 2016. Some patients at Townend Court were there from other areas.

Staff told us that discharging patients could be problematic at times. The main reason for this was lack of suitable placements for patients to be discharged to and awaiting suitable care packages in patients' own homes. There were also issues with planned discharges and transfers taking longer, or not happening due to external issues such as funding. This put pressure on the service in respect of being able to make timely discharges. The doctor and nursing staff told us it was sometimes also difficult when patients were reluctant to move on themselves.

However, we saw staff took action to assist patients to move on to more appropriate community services and ensure a smooth transition. Some patients had care workers from their anticipated community care providers come in to support them on the unit and in the community. This was to help build a relationship and gain knowledge of the patients' needs and how best to support them when they left the service. Discharge planning was started prior to, and continued on admission. Staff discussed discharge planning in the weekly panel meetings. Patients had discharge plans in place although these were not always thorough. Several patients at the time of our inspection had placements arranged and were waiting to be discharged.

The facilities promote recovery, comfort, dignity and confidentiality

There were lounges on the units for patients to spend time. Patients said they could find somewhere spend time alone and when they wanted extra privacy. Staff said carers and visitors could visit patients in their bedrooms if this had been assessed as safe to do so.

The treatment rooms on Willow and Lilac had privacy curtains to maintain patients' dignity during examinations. Beech's privacy curtain was missing. Staff said they would not use the room for personal exams whilst this was not in situ.

There was no card or coin operated phone on the units although each unit had a hands free phone patients could use. Patients requested the phone from staff and could take this somewhere private to make personal calls. We saw patients were able to use the phone at their request.

Are services responsive to people's needs?

Good

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

Patients were able to have their own mobile phones with them on the unit. There was no internet access. Staff and patients said they were getting some equipment soon that would allow them access.

All units offered direct access to outside space, which included a smoking area and seating areas. We saw patients making use of this during our visits.

At the focus group, some patients said the food was healthy but felt the portions were too small. We saw that patients had also raised this at a previous patients meeting. Staff had encouraged patients to ask for more if they were not satisfied. During our inspection, patients and carers spoke positively about the food. Some patients said they had takeaways on a weekend. Carers said there was a good choice of food. The service scored 99.44% for 'ward food' as part of the 2015 patient-led assessments of the care environment score

One patient said they would like to be more involved in meal preparation as part of their rehabilitation but there was no cooker on the rehabilitation unit. There were facilities for patient to make snacks. There was a cooker in the activities room where patients could cook with the occupational therapist.

Some patients had raised at the focus group they felt limited as to what they could have to drink at night. During our inspection, patients said there were no restrictions and they could get up and have drinks when they wanted. Staff also said patients could have snacks and drinks at any time. Although there were kitchens where patients could make these, patients did not have sole access to these. This meant patients would need a staff member to be available to let them in.

With their permission, we looked in five patient's bedrooms. We saw that rooms were personalised to people's own individual tastes. Patients had lockable safes where they were able to keep their own possessions secure. Patients were able to have keys to their own rooms.

Activities were available for patients seven days a week. Three activities workers had very recently come into post. One was currently not at work. They worked flexibly to meet the needs of the patients. Staff told us the recent implementation of these posts had been a big help. Patients said they participated in number of different activities. These included trips out, gardening club, walking groups and arts and crafts. An activities worker we spoke with told us they took into account patients likes and dislikes to formulate meaningful activities.

Meeting the needs of all people who use the service

There was disabled access onto the units and assisted bathrooms that disabled patients could use. All rooms on the units were ensuite.

On Lilac there was no information displayed on the notice board for patients. However, there were a number of communal folders for patients to access providing advice about employment, religion, care planning and local services. There was less information for patients on Beech and some information on the notice board on Willow. Staff said they would be able to provide information for patients on request and this was available in different formats and languages.

Staff told us they had access to interpreters and these had been used in the past where needed. For example, to help assess patients' needs and explain their rights. Signs and notices around the units were written in an easy read format to help aid patient's understanding.

The cook told us they could serve meals to suit patients' individual dietary requirements. This may be where someone needed a specialised diet or required meals to be prepared in accordance with religious or cultural protocols.

Patients also told us that they could ask staff about arranging access to spiritual support should they require this. Staff told us they would be able to accommodate any such requests.

Listening to and learning from concerns and complaints

Patients told us they would either speak to staff, managers or their advocate if they had any complaints to make. When they did raise any concerns, they said staff would try to resolve the issues.

We saw a staff member supporting one patient to discuss a situation they were unhappy about. At all stages, the staff member asked the patient for their views and how they wanted to deal with the situation. The staff member, with the patient's permission and at their request, agreed to take this forward for them as a complaint. This showed that

Are services responsive to people's needs?

Good

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

staff were responsive to patients' complaints and made efforts to find solutions to this. Staff were aware when they would need to escalate complaints and the process to follow to do this.

There was no information on display in the units to advise patients of the complaints process, where else they were able to complain to and their right to contact the Care Quality Commission. This meant that patients might not be fully aware of all avenues available to them if they concerns about the service. Several patients said they would look at information in their welcome packs when we asked how they would make a complaint. The welcome packs did not tell patients about their right to contact Care Quality Commission either.

In the last 12 months there had been one formal complaint made about the service. This had been partially upheld by the trust. There were currently no complaints being investigated by the service. Staff were aware of the duty of candour. All staff we spoke with were able to describe what this meant and there was a duty of candour policy for staff to access. Carers told us of instances where staff had informed them immediately when any mistakes had been made.

During our inspection, we received three comment cards about Townend Court. All three were positive compliments about the service. One person also contacted us directly to pass on positive feedback. The service had received five compliments in the last 12 months.

Are services well-led?

Requires improvement

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

The senior managers had a clear vision for the service. They said they knew they were not quite there yet but were clear what they wanted to achieve. Long-standing staff said that at times it had been hard going with the changes that had taken place. However, they were excited about where the service was going in adopting a more multidisciplinary approach. Staff said the service was very person centred and caring and this was what they were most proud of.

The service manager and modern matron were based at Townend Court and all staff knew who they were. They told us they also spent time on the units. Staff were aware of the senior managers up to clinical care director level for their service. Staff told us the chief executive had attended the service several weeks prior to our inspection. The medical director also worked from Townend Court part of the week. We saw the senior managers present throughout our inspection.

Good governance

Systems were in place for managers to monitor training, supervision and appraisals and staffing levels. Some mandatory training figures were lower than the trust target although figures had been improving. Managers recognised this needed to improve further. Supervisions and appraisals had also improved.

We found there were still areas for improvement that had not been fully addressed by management. Managers were not routinely reviewing incidents in a way that could identify trends and themes due to a backlog. We looked at the minutes of the previous three unit managers meetings prior to our inspection. The earliest of these were from 11 February 2016. Outstanding Datix reports was listed as a risk. It said an action plan was required as to how this would be addressed. This action was still outstanding in the last minutes we saw dated 18 March 2016 and no action plan was in place at the time of our inspection.

On 11 February 2016, another action was that weekly reports needed to be provided in order to review the use of seclusion and restraint. The reports were still not in place at the meeting of 18 March 2016.

Other areas of concerns we found during our inspection, had not been identified at management level. Not all reportable incidents were being reported on Datix. Some patients did not have appropriate risk assessments in place and potential safeguarding concerns had not been identified and reported. Information from staff differed to what was recorded in terms of prone restraint.

There were no set key performance indicators specific to the service to use in order to gauge performance. The provider said that as part of the transforming care program for learning disability inpatient units they had identified areas in which to develop key performance indicators. These related to the length of stay and delayed discharges, however these were not yet in place.

Leadership, morale and staff engagement

The unit manager had general management of all three units and was supported by four deputy managers. There was administration support available to the management team.

Trust data showed the service had the lowest percentage of vacancies out of the mental health services. Sickness rates overall from 1 December 2014 to 30 November 2015 were 3.3% which were below the trust average of 4.9%.

Staff were aware of how to use the whistleblowing system. The Care Quality Commission had received information previously through this process that the service had responded to.

Staff told us that the management were very approachable and they felt confident with their leadership. One staff member who had transferred from another part of the trust said they felt greatly supported by the managers at Townend Court. Staff said they felt able to raise any issues.

Morale amongst staff was good. New staff said they felt supported and part of the team. Staff were encouraged to progress and develop in their careers. Many staff had worked at the service for a significant length of time. Managers told us what they were most proud of was that the team was caring.

Issues concerning staff conduct had been acted upon and dealt with in accordance with necessary procedures.

Commitment to quality improvement and innovation

The service participated in the Royal College of Psychiatrists' quality network for learning disabilities to keep up to date with good practice and new guidance. The

Are services well-led?

Requires improvement

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.

network included professionals, carers and patients. The learning disability clinical care group director and consultant psychiatrist participated in this process as core members. The attendance was to be extended to the modern matron and unit manager in future.

Several patients had tablet computers provided by the trust. These incorporated an application (app) called 'my health guide app'. This app had come from an original concept commissioned by Humber NHS Trust. It had been adapted for use in the learning disability services. One of the deputy managers at Townend Court had worked with the developers on the app.

The apphelped patients to own their information and take a role in their own health care. Patients could customise the app so that it was personal to them. Information could be recorded in a number of ways such as text, audio, video and images. The app also allowed professionals, with the patient's agreement, to add content that could help in understanding and reinforcing professional advice. We saw a patient using theirs during our inspection.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care records did not always reflect service users needs and preferences in all areas where they required support and provide a holistic view of the service user. There was a lack of clear information about what treatment service users needed and progress towards recovery. This was a breach of Regulation 9 (1) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered provider had not assessed all risks relating to the health and safety of service users receiving care or treatment. The registered provider had not done all that was reasonably practicable to mitigate risks. Service users records showed all known risks had not been assessed. Risks plans were not always reviewed and updated as required. All areas of the environment had not been fully assessed to ensure risks were identified and mitigated. This was a breach of Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes did not operate effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse. Incidents that met the threshold for safeguarding consideration were not always referred to, or discussed with, the safeguarding team as necessary. Interventions where service users were controlled or restrained were not subject to review to ensure these were necessary to prevent, or a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. This was a breach of Regulation 13 (1) (3) (4) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: All reportable incidents at the service were not being reported on the trust's incident reporting system. Due to a backlog, incidents were not being monitored routinely to identify trends and themes. Outstanding actions at service level were not always followed up in a timely manner. The service had no set plan of what training, outside mandatory, staff were required to have to ensure they were equipped for their roles. This was a breach of Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Not all staff had completed necessary mandatory training. There was no evidence that all relevant staff had appropriate skills to support patients with learning disabilities and mental health conditions. This was a breach of Regulation 18 (2) (a)