Good

Cumbria, Northumberland, Tyne and Wear 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)
RX40B	Carleton Clinic	Wards for people with learning disabilities or autism	CA1 3SX
RX467	Northgate Hospital	Wards for people with learning disabilities or autism	NE61 3BP
RX4Y0	Rose Lodge	Wards for people with learning disabilities or autism	NE31 2TH

This report describes our judgement of the quality of care provided within this core service by Cumbria, Northumberland, Tyne and Wear 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 the trust and these are brought together to inform our overall judgement of the 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	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Outstanding** 

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

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Summary of findings

Overall summary

Our overall rating of this service went down. We rated it as good because:

- Managers did not always ensure that staff had the range of skills needed to provide high quality care and did not always fully support staff with supervision or team meetings.
- Staff did not always assess and manage risks to patients and themselves well. Risk assessments were not always kept up to date and did not always reflect the current patient need. The management of long-term segregation and seclusion, and the use of mechanical restraint, did not always meet with best practice.
- Staff did not always develop holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff did not always follow physical healthcare plans in place for patients and were not always aware of the content of these.
- Staff did not always demonstrate clear understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and did not always act in line with the Mental Health Act Code of Practice.

However:

- Staff had received basic training to keep people safe from avoidable harm.
- The wards were generally safe and clean, with enough nursing and medical staff, who knew the patients. The ward staff participated in the provider's restrictive interventions reduction programme and understood how to anticipate and de-escalate challenging behaviour.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff undertook functional assessments when assessing the needs of patients and provided a range of treatment and care for patients based on national guidance and best practice.
- The ward team included the full range of specialists required to meet the needs of patients on the ward.

Summary of findings

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

Are services safe?

Requires improvement

At our last inspection of this core service in September 2016 we rated the key question of safe as good. Although we did not look at all the key lines of enquiry on this inspection, we did find evidence that the services inspected were in breach of regulation and as result the rating for the safe key question has been limited to requires improvement.

Our rating of safe went down. We rated it as requires improvement because:

- Wards were not always well equipped, well furnished, well maintained and fit for purpose. At Edenwood, the ward had been appropriately furnished but was damaged regularly by the patient being nursed in long-term segregation. The patient had access to section 17 leave, however, was unable to access outdoor space directly from the ward. The patient's leave had been suspended for a two-week period in January 2020, resulting in the patient not having access to fresh air for this time. The environment at Edenwood was sparse with a bare concrete floor and minimal furnishings despite concerns having been raised in November 2019. The trust had made progress with making adaptations to the environment, but the trust's estates did not have clear timescales in place as to when works were to be completed regarding the floor and access to outdoor space.
- Staff did not always assess or manage risks to patients well. Patients' risk assessments were not always reflective of patients' current need and were not always kept up to date. At Mitford Ward, ward managers did not have accurate oversight of the usage of mechanical restraint on the ward. At Rose Lodge, post-incident review forms were not always completed after uses of mechanical restraint and group director level authorisation was not always clearly recorded for uses of mechanical restraint.
- Staff on Mitford Ward and at Rose Lodge did not always review episodes of long-term segregation in line with the Mental Health Act Code of Practice or record clearly the frequency and outcome of reviews they had done.

However:

- The service had enough nursing and medical staff, who knew the patients well.
- Staff had the skills required to implement good positive behaviour support plans and followed best practice in

Summary of findings

anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Are services effective?

Outstanding ☆

At our last inspection of this core service in September 2016 we rated the key question of effective as outstanding. We did not look at all the key lines of enquiry for the effective domain and as result we did not rate this key question.We found the following issues of concern;

- Care plans did not always meet the needs of patients and were not always personalised, holistic and strength based. Care plans did not always include the required information for staff to correctly support patients' in the management of their physical healthcare. At Mitford Ward and Rose Lodge, staff were not always aware of the content of patients' physical healthcare plans and did not always follow these.
- Managers did not always use audits to make improvements. Audits in place at both Mitford Ward and Rose Lodge were not effective as they did not always identify issues. Actions taken to address non-compliance or areas of improvement were not always clearly recorded or documented.
- Managers did not always support non-medical staff through regular clinical supervision of their work. Staff at Edenwood and Rose Lodge were not always able to leave their duties on the ward to complete supervision sessions.
- Managers did not always make sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff did not always have access to training regarding learning disabilities and autism and were not always experienced in working with this patient group.

However:

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies and providing support for self-care.

Summary of findings

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. We saw evidence within patient records across all three wards visited of regular multi-disciplinary input into patients' care.
- Managers provided an induction programme for new staff.

Summary of findings

Information about the service

We conducted a focused inspection of wards for people with a learning disability or autism at three locations run by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. We inspected these services to find out whether improvements to deal with concerns about some complex care issues were being addressed after a period during which we had been monitoring progress. We also needed to check on the quality of services due to other concerns raised with us about the services inspected. We visited the following locations;

Mitford Ward, Northgate Hospital, Morpeth - Mitford Ward is a 15-bed ward for patients with a primary diagnosis of autism. At the time of inspection there were two patients being nursed in long-term segregation on the ward.

Edenwood, Carleton Clinic – Edenwood had been closed to admissions and was continuing to be used to nurse one patient with a learning disability and complex needs in long-term segregation. Other patients who had previously been cared for at Edenwood had been transferred to another ward on the site which continued to provide learning disability assessment and treatment services to this patient group. Edenwood came under the management of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust from Cumbria Partnership NHS Foundation Trust on 1 October 2019.

Rose Lodge, Hebburn – Rose Lodge is a mixed-sex 12-bed assessment and treatment ward for patients with a learning disability. There was one patient being nursed on the ward in long-term segregation and one patient being nursed in seclusion on the ward.

The wards are registered to provide the following regulated activities;

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

The last inspection of the Learning Disability and Autism wards was completed in September 2016, which included Rose Lodge. These services were rated as outstanding overall. Edenwood was not included in this inspection as this service was transferred to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust on 1 October 2019. Mitford Ward was not included in this inspection as this service was opened in November 201.

We conducted an unannounced focused inspection looking at specific areas of the following two key questions:

- Is it safe?
- Is it effective?

Our inspection team

The team comprised of three CQC inspectors, one CQC assistant inspector and one specialist advisor who was a registered learning disability nurse.

Why we carried out this inspection

We conducted a focused inspection of wards for people with a learning disability or autism at three locations run by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. As part of this inspection, we visited the following wards;

Mitford Ward – Northgate Hospital, Morpeth

Rose Lodge – Hebburn

Edenwood – Carleton Clinic, Carlisle

We inspected these services to find out whether improvements to deal with concerns about some complex care issues were being addressed after a period during which we had been monitoring progress. We also needed to check on the quality of services due to other concerns raised with us about the services inspected.

Summary of findings

The last inspection of the Learning Disability and Autism wards was completed in September 2016, which included Rose Lodge. These services were rated as outstanding overall. Edenwood was not included in this inspection as this service was transferred to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust on 1 October 2019. Mitford Ward was not included within this inspection as this service opened in November 2016.

At our last inspection of this core service in September 2016 we rated the key questions of safe as good and effective as outstanding. Although we did not look at all the key lines of enquiry on this inspection, we did find sufficient evidence that the services inspected were in breach of the Health and Social Care Act (regulated activities) regulations 2014 and as a result the rating for the safe key questions has been changed to requires improvement. We found some areas of concern in the effective key question; however, we did not have sufficient evidence to re-rate at this inspection and therefore the rating for this key question remains outstanding. The ratings for caring, responsive and well led remain unchanged as we did not inspect these key questions.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited three wards at three different locations, looked at the quality of the ward environment and observed staff caring for patients
- spoke with the ward managers and clinical leads of each ward
- spoke with 21 other staff members across the three wards, including doctors, speech and language therapists, nursing assistants, nurse specialists and occupational therapists
- reviewed four long-term segregation records
- reviewed one set of seclusion records
- observed three long-term segregation reviews
- spoke with four patients
- observed one music therapy session
- looked at 10 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the wards.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the patients in long-term segregation and seclusion have the appropriate safeguards in place in accordance with the Mental Health Act Code of Practice and these are documented clearly in patients' records. **Regulation 13.1**
- The trust must ensure that the environment at Edenwood is improved including the provision of specialist furniture which meet the needs of the patient using this service**. Regulation 13.1**
- The trust must review and reduce the use of mechanical restraint within their learning disability services and ensure that its use is in line with best practice guidance and the appropriate authorisation and recording is in place. **Regulation 17.2 (a)**
- The trust must ensure that risk assessments are regularly updated to reflect current risk and needs of patients. **Regulation 12.2 (a)**
- The trust must ensure that care plans contain the relevant supporting information, reflective of current need, regularly updated and that staff are aware of these and follow plans accordingly. **Regulation 9.3 (b)**

Action the provider SHOULD take to improve

- The trust should ensure that audits are reviewed to ensure they are fit for purpose and that actions taken to address any noncompliance identified by the audit process are documented clearly.
- The trust should ensure that staff and patient debriefs take place after incidents, and that they are clearly documented and recorded.

Summary of findings

- The trust should ensure that all staff receive learning disability and autism training.
- The trust should ensure that staff comply with the Mental Capacity Act by completing the relevant assessments to support their decisions and that these are documented within patient records.
- The trust should ensure that staff receive regular and timely supervision to support them with their roles.

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

The wards were generally safe and clean. Rose Lodge and Mitford Ward were well furnished, well maintained and fit for purpose, however, we had concerns about the environment for the patient cared for at Edenwood.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We reviewed the ward environment of Edenwood, Mitford Ward and Rose Lodge. At Mitford Ward repairs were scheduled to be made to a patient's flat which was not currently in use as the patient had been moved to the seclusion room on the ward to allow repairs to take place. There had been delays in the repairs being done by an external contractor meaning that the patient could not return to the environment as quickly as planned. Staff at Mitford Ward told us that they were able to report any issues with the ward environment to the nurse in Charge or Ward Management who would be able to escalate these to the trust's estates team.

Staff could not always observe patients in all parts of the wards due to the layout of the environment at all three of the wards visited. This risk was mitigated via observation levels which were allocated to patients dependent on their level of need and the risk they presented. We reviewed patients' observation levels at all three of the wards visited and patients were observed with a minimum of one to one staffing.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe using observations. There was closed circuit television across all three wards. This was not routinely monitored by staff but was used as an aid to review incidents and there were appropriate policies and procedures in place to manage this.

Staff across all three wards had easy access to alarms but patients did not always have easy access to nurse call systems. At Mitford Ward, patients did not have access to nurse call alarm systems within their individual flat areas but call alarms were present in communal areas on the ward. We raised this with the trust who provided a response outlining the rationale for not including nurse call alarms at Mitford Ward in the individual flat areas. Alarms had not been installed to ensure a low stimulus environment by reducing any protruding wall mounts (e.g. power sockets, light switches) to ensure the environment did not cause unnecessary distress to patients. The trust outlined that patients at Mitford Ward received a bespoke package of care and due to the level of need of the patients within the service, staff support was present twenty-four hours a day.

Maintenance, cleanliness and infection control

Ward areas at Rose Lodge and Mitford Ward were visibly clean, well maintained, well-furnished and fit for purpose. During the inspection of Mitford Ward, it was noted that although two of the patient bedrooms (of which only one was in use) were visibility clean they both had a strong, unpleasant odour. We raised this within the feedback to the ward management at the time of inspection.

At Edenwood, the ward environment was sparse. This was due to the specific needs of the patient being nursed on the ward and the challenges they presented to the service on maintaining furniture and fitting in the ward. The lounge had no floor covering. There was a bench type seat with bare wood and no padding to sit on. In the bedroom, there was a bare mattress on the floor. These issues had previously been raised as a concern following a Mental Health Act monitoring visit in November 2019. Specialist flooring had been identified as the most suitable option to address issues with the flooring, however this could not be installed without the ward being vacated which would cause significant distress to the patient. Staff told us that alternative flooring samples were on order and that the flooring would be replaced. The trust's estate team did not have a clear timescale for completion of this work. Staff had ordered a specialist bed and specialist sofa which both had a 12-week lead-time. Staff told us they expected these to be delivered in the two weeks following our inspection.

At Edenwood, there was an outside area that at the time of the inspection could not be accessed by the patient being nursed on the ward as this space had not been adapted to meet the needs of the patient. The patient had been regularly utilising section 17 leave; however, this had been

suspended for a two-week period in January 2020 that meant during this time the patient did not have access to fresh air or outside space. We raised this with the trust who provided a response stating that the estates team had been contacted to attend the ward to review the outdoor area and assess the changes that would need to be made to make the space suitable and safe to be used by the patient, however the trust's estate team did not have a clear timescale for the completion of the changes to be made.

Staff made sure cleaning records were up-to-date. The wards were cleaned daily by housekeeping staff who kept records of the tasks they had completed.

Staff followed infection control policy, including handwashing. There were hand cleaning gels at entrances to the ward.

Seclusion room

The seclusion rooms on all three wards allowed clear observation, two-way communication and all had a toilet and a clock.

Safe staffing

The service had enough nursing and medical staff, who knew the patients although not all had received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Across all three wards there had been a reliance on bank and agency staff. Staff sickness levels at Rose Lodge were 15% for January 22% for February and at the time of the inspection there were two band 5 vacancies, and five band 3 vacancies. This had resulted in an increase in the use of agency staff at the service.

At Edenwood for February agency staff usage was at 35% for day shifts and 27% for night shifts. At the time of the inspection, Edenwood had one band 6 vacancy, 3 band 5 vacancies as well as 0.6 WTE band 4 occupational therapist post and 0.4 WTE psychologist post vacant. The trust had acted to mitigate the risk of this and provide stability to patients. At Edenwood, the trust had secured temporary contracts with named bank and agency staff to provide some consistency in staff working onto the ward, and to offset the impact of some vacancies and staff sickness. At Rose Lodge and Mitford Ward, management requested specific agency staff to work on the ward who were familiar to the service to ensure consistency in their staff team.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Agency staff at all three wards visited completed a local induction at the service.

Managers accurately calculated and reviewed the number and grade of nurses and nursing assistants for each shift. Across all three wards, managers ensured that there was an appropriate mix of grades and skills within staff teams on shift. Staffing levels across all three wards met the trust's designated safer staffing levels.

Ward managers could adjust staffing levels according to the needs of the patients. At Rose Lodge, the ward manager had been authorised to recruit 10% above their establishment level in order to be able to respond to patient need. At Mitford Ward, staffing levels were discussed as part of multi-disciplinary team meetings and care programme approach meetings and could be adjusted where required.

Patients had regular one to one sessions with their named nurse and where patients presented with complex needs they were allocated core staff teams to work with them.

Patients rarely had their escorted leave, or activities cancelled, even when the service was short staffed. Staff at Mitford Ward and Rose Lodge told us that management would re-allocate staff to ensure leave could be facilitated.

The service had enough staff on each shift to carry out any physical interventions. Managers at both Mitford Ward and Rose Lodge ensured that there were sufficient numbers of staff present on shift trained in mechanical restraint to respond to incidents where this was required. Staff who had recently been redeployed to Rose Lodge told us they did not always feel confident in using their prevention and management of violence and aggression training as this was not something used frequently in their previous service. We raised this with the ward manager who told us that a programme was in place to refresh all staff members prevention and management of violence and aggression training.

Some staff at Rose Lodge told us that they did not always feel safe when working on the ward. Staff at Rose Lodge told us that they had concerns about being able to respond to incidents in a timely manner. The service did not have a clear protocol for how staff would respond when staff alarms were activated. Staff felt that this may lead to feeling compromised between maintaining their

observations for allocated patients or responding to incidents. The service was in an isolated location, however the ward manager stated that staff could seek support from other services if this was required.

Staff were not always able to share key information to keep patients safe when handing over their care to others. At Rose Lodge, staff told us that the 10-minute hand over was insufficient to convey any changes to care plans, current risks, incidents and patient's presentation. We saw evidence at Rose Lodge that patient's daily handover sheets did not always accurately reflect their presentation. At Mitford Ward, staff told us that the Situation, Background, Assessment and Recommendation (SBAR) process formed a key part of handovers. Staff told us that additional time after handover had been arranged so that staff allocated to observations with patients' with more complex needs could discuss patients' handover in more detail.

Medical staff

All of the wards visited had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Mandatory training

Staff had not always completed and kept up to date with their mandatory training. Managers did not always monitor mandatory training and did not always alert staff when they needed to update their training. At Edenwood, the figures regarding mandatory training compliance were low. We raised this with the trust who provided an update outlining that the trust was aware of this issue and had agreed a six-month period of reviewing all quality and training standards from the date of the acquisition of Edenwood. This review was ongoing at the time of the inspection and that this had been agreed with wider stakeholders. At the time of the inspection, the trust had recently introduced an enhanced training standard in 2020 which included a programme of mechanical restraint training in addition to the current PMVA training. At Mitford Ward, training for mechanical restraint was only at 27%. The trust outlined that compliance across all services was not expected until December 2020 and mitigated the impact of this by ensuring that staffing rotas were managed to ensure there were sufficient staff on shift trained in mechanical restraint to respond to incidents safely. We reviewed a list of all staff members trained in mechanical restraint at the time of our inspection alongside incident reports relating to episodes of mechanical restraint. We found that not all staff listed as being involved in the incidents of mechanical restraint had been trained in MRE. We raised this with the trust who reviewed the individual training records of staff, which detailed these staff members had been trained in mechanical restraint. We raised this as a concern that there were discrepancies between the list provided and individual staff training records.

The mandatory training programme was comprehensive and met the needs of patients and staff. The trust's mandatory training programme included the relevant health and safety modules, safeguarding training and combined Mental Health Act, Mental Capacity Act and Deprivation Liberty Safeguards training.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. The ward staff participated in the provider's restrictive interventions reduction programme, however the management of long-term segregation, seclusion, and the use of mechanical restraint, did not always meet with best practice. Staff had developed and implemented positive behaviour support plans and understood how to anticipate and de-escalate challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, but these were not reviewed regularly and were not always updated to reflect changes in risk.

Staff always used a recognised risk assessment tool. The functional analysis of care environments (FACE) risk assessment tool was used by staff across all three wards that we visited.

Management of patient risk

Staff were not always aware of and did not always deal with specific risk issues. We reviewed 10 patient records across all the wards visited which all contained a risk assessment. At Rose Lodge, we found that the risk assessment for two patients' had outlined specific risks relating to the patient's – but there were no corresponding care plans in place. We also reviewed the risk assessment for one patient which had not been updated since September 2019. Another patient was identified as having a speech and language

therapy care plan on their daily handover sheet but there was no care plan present within the patient's record. We raised this with staff who told us that this was no longer a risk for the patient and that the risk assessment for the patient had not been updated to reflect this.

Staff did not always identify and respond to any changes in risk to, or posed by, patients. Staff were not always provided with the most up to date information relating to patient risk, as care plans and risk assessments were not always kept up to date, meaning that there were discrepancies between staff understanding of patient's risk and how to manage this versus the actual risk presented by patients. At Mitford Ward, in order to mitigate this risk, paper copies of patients' positive behavioural support plans were kept in files outside of each patient's flat to be used by staff allocated to observations. These did not always contain the most up to date version of plans and were not always reflective of current need and risk.

We reviewed documentation on all three wards regarding the four patients being cared for in long-term segregation. At Mitford Ward, we reviewed documentation that outlined that the most recent three-monthly review for a patient in long-term segregation had not taken place. At Rose Lodge, we reviewed documentation for a patient in long-term segregation that did not include documentation to support that weekly multi-disciplinary reviews or monthly independent reviews had been taking place. We raised this with the ward management at both Rose Lodge and Mitford Ward as the correct safeguarding measures had not been applied for those patients being cared for in long-term segregation.

Staff at Rose Lodge told us they were allocated to four-hour long periods of observation and sometimes spent their entire shift on eyesight level observations, which they found draining and challenging. The trust policy stated that staff should not be allocated to continuous periods of observation higher than general level for longer than two hours.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. There were trust-wide restrictions in place at all three wards visited. Staff at all three wards told us that aside from the trust-wide restrictions, any other restrictions in place for patients were assessed, implemented and reviewing on an individual basis.

The trust lacked oversight of the use of mechanical restraint. At Mitford Ward when reviewing incidents relating to mechanical restraint that involved the use of belts and soft cuffs for January 2020 – March 2020, the inspection team noted that four incidents had been reported and documented within patients' progress notes with corresponding incident numbers. Four of these incidents had not pulled through into the main dashboard. We highlighted the issues with the dashboard system with the trust, who responded by submitting a request for this data to be audited.

On Mitford Ward, we reviewed a mechanical restraint care plan for one patient. Within the care plan, there was no documentation regarding the deployment of soft cuffs to be used in an episode of mechanical restraint, and the deployment strategies only outlined the usage of four belts. We reviewed incident details relating to episodes of mechanical restraint we noted that soft cuffs had been used by staff to restrain the patient. There was no documented rationale as to why the usage of cuffs had been deployed alongside the four belts and that director level authorisation for the usage of soft cuffs had not been documented.

At Rose Lodge, we reviewed two post-incident review forms relating to incidents of mechanical restraint on the ward. We found issues with the forms not always being completed in full with the required detail, forms did not always document if a group level director had been contacted for authorisation and that this had been obtained and that staff and patient debriefs did not always take place after incidents of mechanical restraint and debriefs were not always recorded. There had been a further incident of mechanical restraint on the ward, however a post-incident review form had not been completed and it was not clear that director level authorisation had been sought for this usage of mechanical restraint.

Staff at all three wards told us that they attempted to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff across all three wards were able to detail de-escalation techniques

that they used with patients to ensure that restraint was only used as a last resort. At Rose Lodge, we saw that activity boxes had been placed around the ward for staff to access quickly to use and offer activities as a method of de-escalation.

At Rose Lodge, we reviewed documentation in relation to a patient that was being cared for in seclusion at the time of the inspection. Staff were able to provide a verbal rationale as to why seclusion had not yet ended, however the corresponding documentation did not reflect the rationale that had been provided. Seclusion observation records and daily handover notes did not contain detail to support the rationale for seclusion to continue.

We reviewed documentation on all three wards regarding the four patients being cared for in long-term segregation. At Mitford Ward, we reviewed documentation and the most recent three-monthly review for a patient in long-term segregation had not taken place. At Rose Lodge, the documentation for a patient in long-term segregation did not include detail of the weekly multi-disciplinary reviews or monthly independent reviews. We raised this with the ward management at both Rose Lodge and Mitford Ward as we were concerned the correct safeguarding measures had not been applied for those being nursed in long-term segregation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff kept up to date with their safeguarding training. Staff received training on how to recognise and report abuse, appropriate for their role. All staff at Mitford Ward and Rose Lodge completed safeguarding adults Level 1 and Level 2 as well as safeguarding children training Level 1 and Level 2 as part of their mandatory training package. Staff undertook a refresher course of their safeguarding training every three years.

Staff could give clear examples of how to protect patients from harassment and discrimination. Staff at all three wards explained the importance of understanding patients on an individual basis and that they would be vigilant for changes in patients' presentation or any change to their normal behaviour.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff across all three wards referred safeguarding concerns to the local authority safeguarding team and advised other relevant agencies such as commissioners and police when needed. Staff displayed a good level of knowledge of the safeguarding procedure and were able to clearly identify their point of contact for escalating concerns. Staff felt comfortable and able to raise concerns with the nurse in charge or ward manager if required.

Staff made safeguarding referrals when patients were cared for in long-term seclusion. At Rose Lodge, safeguarding referrals had been submitted regarding the patient who was being cared for in seclusion at the time of the inspection. At Mitford Ward, we reviewed long-term segregation documentation that outlined regular communication and updates being provided to clinical commissioning groups regarding ongoing episodes of long-term segregation.

Staff access to essential information

Staff did not always have easy access to clinical information, and it was not always easy for them to maintain high quality clinical records. Staff at Mitford Ward used entirely electronic systems, but staff at Edenwood and Rose Lodge used a combination of electronic and paper records. Records were stored securely across all three wards as a secure electric computer system was used and where paper record were kept these were stored in locked offices.

At Mitford Ward, we found that the paper copy of a patient's positive behavioural support plan that was located outside of patients' individual flat area was not the most up-to-date version. We raised this with staff as we questioned how staff allocated to observations for patients would be able to access the most recent version of patients' positive behavioural support plans. Staff actioned this by replacing the positive behavioural support plan with the most recent version. Staff told us that they were able to access laptops on the ward and that the allocated time for handover was sufficient to discuss patient's needs and any changes in presentation and risk.

At Rose Lodge, we reviewed a patient's record that did not include a positive behavioural support plan. We raised this with staff who were able to provide a copy of the positive behavioural support plan from another staff members

Requires improvement

Are services safe?

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

computer. Staff highlighted that this was where the plan had been stored, but it was not clear if this had been saved on a shared drive that all staff could access or saved locally to the staff member's laptop.

Are services effective?

Outstanding ☆

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

Staff undertook functional assessments when assessing the needs of patients who would benefit. Care plans did not always reflect the assessed needs and were not always personalised, holistic and strengths based.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 10 sets of care records across three wards and saw that staff assessed the physical and mental health of all patients on admission.

Staff developed a care plan for each patient that met their mental and physical health needs however staff were not always aware of care plan contents and did not always follow these accordingly. We found issues with six of the ten records that we reviewed across the three wards visited. At Mitford Ward, we reviewed a patient's care plans that instructed staff to use supplementary documents to help the patient communicate as they used their own specific versions of gestures and signs that differ from Makaton (a language programme to help hearing people with learning or communication difficulties). These supplementary documents were not kept on file for staff to use and it was unclear how staff were communicating with the patient in a way they understood.

Positive behaviour support plans were present and supported by a comprehensive assessment. We reviewed 10 sets of patient records, in which a positive behaviour support plan was present. Plans were reflective of patient need and provided staff with clear strategies as to how to support patients. Staff understood patients' positive behavioural support plans and were able to provide the identified care and support. Staff across all three wards demonstrated a good understanding of what support individual patients required, how they would identify changes in presentation and were able to outline the strategies that they would use to de-escalate situations.

However, staff did not always regularly review and update care plans and positive behaviour support plans when patients' needs changed. At Rose Lodge, we reviewed a positive behaviour support plan for a patient that had identified areas of risk, but no corresponding care plans were in place to manage these. At Mitford Ward, we observed care and treatment being delivered that was not in line with patient's care plans regarding the management of constipation. Staff informed us that this was no longer an issue for the patient, but that their care plan had not been updated to reflect this being discontinued.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. Patients across all three wards visited had access to psychological therapies, activity sessions on a one-to-one basis such as music and dance therapy and group-based activity sessions. Staff did not always support patients with their physical health and did not always follow patients' physical healthcare plans. Ward Managers completed audits but did not always use these to make improvements.

Staff delivered care in line with best practice and national guidance. Staff across all three wards told us that they followed NICE guidance when delivering care and treatment to patients within services.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed 10 sets of patient records that documented regular physical health checks taking place during the patient's admission to the ward.

Staff made sure patients had access to physical health care, including specialists as required. Staff met patients' dietary need and assessed those needing specialist care for nutrition and hydration. Where required, patients had been assessed by a Speech and Language Therapist and plans were developed to assist patients who may be at risk from aspiration and/or choking. At Mitford Ward, we saw evidence in patients' daily notes of involvement with dieticians to look at calorie intake and changes in weight.

However, staff were not always aware of patients' physical health needs or their physical health care plans. At Mitford Ward, care plans stated that staff should follow a supporting document for the management of patients' physical health condition which outlined the signs and symptoms staff were required to be mindful of. This supporting document was not present within the patient file and staff were not aware of the steps outlined to support the patient in their care plan. At Rose Loge we found issues relating to staff's awareness and adherence to

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physical health care plans. We reviewed care plans that detailed staff were required to measure the leg of a patient to manage their oedema, but we saw no evidence to demonstrate that this was taking place

Managers did not always use results from audits to make improvements. At Mitford Ward, we reviewed audits in relation to long-term segregation documentation which had not identified that a three-monthly review had been missed for a patient. At Rose Lodge, we reviewed audits relating to long-term segregation documentation and found that audits had not regularly recorded the dates of the last weekly MDT review and monthly independent review, audits had only partially been complete for the first two weeks of February, that two audits were missing for the last two weeks of February and that details of actions taken to rectify issues identified by the audit process had not been documented.

Skilled staff to deliver care

The ward team included the full range of specialists required to meet the needs of patients on the ward. Managers had not ensured that staff had the range of skills needed to provide high quality care and did not always fully support staff with supervision or team meetings. However, managers provided an induction programme for new staff and offered some opportunities for them to update and develop their skills.

Staff teams across all three wards included occupational therapists, speciality doctors, speech and language therapists, psychologists and positive behavioural support nurses.

Managers did not always make sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. At Edenwood and Rose Lodge, staff told us that they had not received any specific training relating to learning disabilities and/or autism. We asked the trust for further information relating to specific learning disability training provided to staff at Edenwood and the trust provided a response outlining that all substantive staff at Edenwood received positive behaviour support training that has been delivered by the trust Band 7 lead in positive behavioural support. At Mitford Ward staff received a service specific induction package that included a personal skills passport containing a short introduction relating to autism, learning disability, challenging behaviour and mental health.

Staff at Rose Lodge raised concerns with us regarding the skills and experience of agency staff working on the ward. Staff had concerns that agency staff were not always familiar with the patient group, were not willing to work with more complex patients and were not always effective in de-escalating situations. We raised these concerns with the trust, who provided a response outlining the mechanisms in place to ensure that agency staff had the required skills needed to work at the service. The trust had implemented a process of three-monthly audits of those agencies which were used regularly and involved checking a random sample of employee information. Managers at Mitford Ward and Rose Lodge told us that they requested specific agency staff who were familiar with the service in order to ensure consistency within the staff team. We reviewed a sample of staff rota's for Mitford Ward and Rose Lodge that reflected the use of regular agency staff and that there was consistency in the staff team. At Edenwood, a high percentage of agency staff were recruited via a specific agency who supplied Disclosure and Barring Service checks and training records directly to the ward for the agency staff who were working in Edenwood.

Managers gave each new member of staff a full induction to the service before they started work. We reviewed the local induction protocol at Mitford Ward and Rose Lodge, which provided an essential overview checklist to be completed at the start of staff's first shift on the ward. Agency and bank staff were included in the local induction.

Managers did not support non-medical staff through regular supervision of their work. At Edenwood, staff were not receiving regular supervision. In February 2020, supervision compliance was low at 25%. Ward managers and staff at Edenwood told us that staffing capacity and the complexity of the patient on the ward meant that staff could not be released from the ward to participate in supervision sessions. At Rose Lodge, supervision compliance for January was 43%. Staff at Rose Lodge stated that they were unable to leave their duties on the ward to complete their supervision sessions.

Managers' made sure staff attended regular team meetings or were given information from those they could not attend. However, at Rose Lodge, bank staff told us that they were not always included within team meetings or

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provided with regular supervision sessions. Bank staff at Rose Lodge felt this had a negative impact on them, meaning they didn't always feel that they were considered as part of the team at the service.

Managers gave examples of where staff had received any specialist training for their role and gave them the time and opportunity to develop their skills and knowledge. At Rose Lodge, management told us that they were able to provide ad-hoc training sessions to address any gaps in knowledge or provide additional support, this included sessions from positive behavioural support leads from within the service, and sessions on topics such as autism and epilepsy. At Mitford Ward, managers told us that when new patients were admitted to the ward, this would be used as an opportunity to identify any training needs and had previously taken this opportunity to do training around tissue viability and Makaton.

Multidisciplinary and interagency teamwork

Staff held regular multi-disciplinary meetings to discuss patients and improve their care. We reviewed ten sets of patient records across the three wards visited that demonstrated regular discussion and input from the wards' multi-disciplinary team.

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

Staff on the whole demonstrated that they understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. Mental Health Act training was included as part of the trust's mandatory training programme and staff undertook a refresher course of this module every three years. At the time of our inspection we were unable to review current compliance figures regarding training at Edenwood due to an ongoing review of quality and training standards. At Rose Lodge, 85% of clinical staff were compliant with Mental Health Act training. At Mitford Ward, 83% of staff were compliant with Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff at all three wards we visited told us that they felt comfortable approaching the nurse in charge on shift or ward manager to seek support for queries relating to the Mental Health Act and the Code of Practice. Staff knew who their Mental Health Act administrators were and knew how to approach them to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Policies and supporting documents regarding the Mental Health Act were available electronically and easily accessed from the trust's website. However, staff did not always complete and document the appropriate reviews for patients in long-term segregation and seclusion to ensure the appropriate safeguards were in place in accordance with the Mental Health Act Code of Practice. Also, mechanical restraint was not always used is in line with best practice guidance and the appropriate authorisation and recording is in place.

Staff explained to each patient their rights under the Mental Health Act but did not always record these within in the patient's notes when this had been completed. Informal patients were not aware that they were able to leave the ward at will. We spoke with one patient at Rose Lodge who had recently been made informal who was not aware that they were able to leave the ward should they wish to.

Good practice in applying the Mental Capacity Act

Staff did not always support patients to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff were aware of the trust's policy for the Mental Capacity Act 2005 but did not always assess and record capacity clearly for patients who might have impaired mental capacity in relation to some specific decisions. At Rose Lodge, we reviewed a patient's record who had restrictions in place regarding the usage of cutlery, mobile phone usage and management of finance. There were no corresponding capacity assessments in place to support the rationale for these restrictions. We reviewed another patient record that did not contain any information regarding the assessment of capacity whilst they had been detained on the ward. At both Rose Lodge and Mitford Ward we reviewed patients' records and found that care plans were in place to assist patients with their personal care but that there was no corresponding best interest decision or capacity assessment present to support this.

Staff received and kept up to date with training in the Mental Capacity Act and demonstrated good understanding of the five principles. Mental Capacity Act training was included as part of the trust's mandatory

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training programme, for which staff undertook a refresher course every three years. At the time of our inspection we were unable to review current compliance figures regarding training at Edenwood due to an ongoing review of quality and training standards. At Rose Lodge, 85% of clinical staff were compliant with Mental Capacity Act Training. At Mitford Ward, 83% of staff were compliant with Mental Capacity Act Training.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff were aware of and knew how to access. Policies and supporting documents regarding the Mental Capacity Act and Deprivation of Liberty Safeguards were available electronically and easily accessed from the trust's website.

Staff knew where to get advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff at all three wards we visited told us that they felt comfortable approaching the nurse in charge on shift or ward manager to seek support for queries relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff did not always support patients to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision. At Rose Lodge we reviewed two patients' records and Mitford Ward we reviewed two patients' records and found that care plans were in place to assist patients with their personal care but that there was no corresponding best interest decision or capacity assessment present to support this.

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

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

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

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