Eden Supported Living Limited - Bestwood Hospital

Bestwood

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)
1-531825063	Bestwood Hospital	Bestwood Hospital	NG6 8UA

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

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

Bestwood hospital provides care for six patients. The patients have complex needs, some of them have limited verbal communication and half of the patients do not have regular contact from family or friends. They live in their own apartments.

We found there was poor leadership because the management had no clear processes of checking whether safe practice was happening due to lack of ways to monitor performance. Audits had not been carried out. There was no monitoring of whether lessons learnt had been put into practice. The staff had not been provided with any performance monitoring information. Staff supervision, appraisals and team meetings were not occurring regularly. There was no formal risk register. There was an action plan that the hospital had in place, it did not identify the risks and lacked structure. The staff team did not have any team objectives to help them improve practice or work towards the vision and values of the hospital.

Not all staff were trained in using the ligature cutters and defibrillation in an emergency. Staff did report incidents and safeguarding's. Due to the lack of monitoring systems we were not assured that all incidents that should have been reported were.

There was lack of space for storage. There were limited facilities to encourage patients to have a choice of meeting up for activities and lack of staff meeting rooms. This meant that equipment such as mops were stored outside; medication was split between patient's apartments and the clinical room. It also meant that the staff hub, a small communal area was noisy. The noise affected a patient who required a quiet and calm environment. Psychology and psychotherapy were undertaken in the patient's own apartment. This was not always the best place for patient's to talk about difficult issues and leave it behind.

There was a lack of activities for patients and this was affected by the lack of transport available to take them out into the community. There was minimal occupational therapy (OT) input to support rehabilitation.

Staff were not aware of patients' ability to read and write. Communication profiles were either not in place or the plans lacked detailed information. This meant that assessments were not thorough about individual needs and the plans that would support them. Information was not available to patients in an easy to understand format. There were no other ways of communication used to help patients understand information given to them.

The psychiatrist, speech and language therapist (SALT) and psychologist were employed for two sessions per week. This meant there was little time available to undertake weekly reviews of all patients and work with individual patients. Support workers were not involved in the clinical team meetings. Support staff were not clear about what they should do to carry out the plans following clinical meetings or psychotherapy sessions with patients.

There were restrictive practices in place in which stable doors were kept locked by staff and opened following a nurse's decision.

Patients did not have copies of their care plans. Care plans were not focused on recovery and there was little recording of discharge planning.

Some patients had limited verbal communication and were not able to tell us in detail what they thought about the care. They did not give any negative comments. Carers were satisfied with the care, although some found the travel from out of the area difficult and others were concerned about the lack of activities. Staff were caring and committed.

Staff did not have an understanding of the MCA and DoLS and how and when this applied to people who were detained under the MHA.

There was no management overview of whether safe practice was occurring due to the lack of performance monitoring.

We issued a warning notice relating to regulation 17 HCSA (RA) 2014 good governance.

Summary of findings

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

Are services safe?

We found that services were not safe because ;-

- There was no management overview of whether safe practice was occurring due to the lack of performance monitoring.
- Ligature audits had not been completed.Not all staff had been trained in the use of a ligature cutter in an emergency. Health and safety audits had not been completed. Not all staff had been trained to use the emergency defibrillator in an emergency. Staff alarms did not work in the outside area of the hospital.
- There was inadequate storage space for mops, buckets and washing machines. Patient medication was stored in two areas.
- Staffing levels were impacted on patient activities and leave. Patients had very few activities and lack of transport affected going out into the community.
- There were 70 incidents reported by staff. Staff knew how to report safeguarding's. Due to the lack of monitoring processes there was lack of assurance as to whether all incidents and safeguarding's were reported.

Are services effective?

We found services were not effective because;-

- Staff were not aware of patients' level of ability to read and write. Communication profiles were either not in place or the plans lacked detailed information. This meant that assessments were not thorough about individual needs and the plans that would support them.
- Clinical audits were not carried out which meant that the team did not have information to improve their practice and how the service was run.
- Staff received little or no managerial and clinical supervision so that they could be supported in reflecting on their practice.
- The psychiatrist, speech and language therapist (SALT) and psychologist were employed for a two sessions per week. This meant there was little time available to undertake weekly reviews of all patients and work with individual patients. Support workers were not involved in the clinical team meetings. The functional analysis of behaviour and treatment were not understood by staff. Staff were not clear what they should do following clinical meetings or psychotherapy sessions with patients.

Summary of findings

Are services caring?

We did not find services to be caring because;-

- Patients did not have copies of their care plans. The needs of people were complex and we did not see innovative ways that people were involved in their care planning. Care plans were not focused on recovery.
- One patient had slept on the sofa as a habit. They were involved in planning the décor of their bedroom. The bed was not made up. This impacted upon their treatment plan to encourage sleeping in a bed.
- Surveys or community meetings did not take place to ask for feedback on the service from patients or carers.

Are services responsive to people's needs?

We did not find services to be responsive because;-

- Discharge planning was not well recorded. Two patients had been ready for discharge last year and were still waiting for placements to be found by commissioners. This meant that they were not able to live in a less restrictive environment.
- There was limited occupational therapy (OT) input and very few activities for patients to do. There was no transport to take people out so that they could access community activities. This meant they were isolated from the wider community.
- Information was not available to patients in an easy to understand format. There were no other ways of communication used to help patients understand information given to them. Behaviours as a form of communication were not well understood by all staff.
- The staff hub area was noisy. One door had a notice to say that quiet was needed. The noise impacted on a patient who required a quiet and calm environment. We observed that the patient was disturbed from the noise out side their apartment throughout our visit.
- There were no complaints for April 2014 to February 2015 and no audits had been undertaken.

Are services well-led?

We did not find services well led because ;-

- There was no clear vision of the purpose of the hospital which was trying to apply the principles of supported living in a hospital setting.
- The governance systems were poor. We were given a folder of audit tools none of which had been implemented.

Summary of findings

- There was no performance management information provided to the staff to monitor performance in relation to supervision, appraisal, training, incidents, safeguarding and staffing.
- The staff did not have team objectives. The lack of learning from audits, complaints, incidents and information about performance did not inform staff of what needed to improve. This in turn did not support individual managerial and clinical supervision sessions.

Summary of findings

Background to the service

Bestwood is an independent hospital for people who are detained under the Mental Health Act and who have a learning disability. The location provided a locked rehabilitation service. There were six occupied self-contained apartments, each with their own garden.

The last inspection was carried out in May 2013 and the hospital was compliant with the standards inspected. A Mental Health Act (MHA) monitoring visit took place in December 2014.

Our inspection team

The team included two CQC inspectors, a CQC national professional advisor (psychiatrist), a CQC senior policy manager, and a expert by experience representative from the challenging behaviour foundation.

Why we carried out this inspection

We carried out a focused inspection of this core service following information provided by our Mental Health Act monitoring visit in December 2014, and the NHS England Improving Lives Team.

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?

During the inspection visit, the inspection team:

- Visited the apartments of patients and observed how staff were caring for patients.
- Spoke with five patients who were using the service.
- Spoke with the three managers for the hospital.
- Spoke with 11 other staff members; including psychiatrist, psychologist, psychotherapist,advocacy, nurses and support workers.
- Spoke with three carers of patients.

What people who use the provider's services say

- No carer or patient feedback surveys had been carried out from April 2014 to February 2015
- Three carers we spoke with had differing experiences. One carer was satisfied with the care and the communication provided. Two carers raised issues related to lack of communication, information and involvement. One carer was concerned about the lack of activities provided which increased the isolation of the individual.
- Some patients had limited verbal communication, however did not make any negative comments about their care.

Summary of findings

- No patient complaints had been received from April 2014 to February 2015.

Areas for improvement

Action the provider MUST or SHOULD take to improve

We issued a warning notice relating to regulation 17 HCSA (RA) 2014 good governance.

- The hospital must demonstrate that it has effective ways to assess, monitor and improve the quality and safety of the services by carrying out audits, producing performance information and obtaining staff, carer and patient feedback.
- The hospital must demonstrate that there are ways of sharing, implementing and monitoring lessons learnt from audits, complaints, incidents and safeguarding's.
- The hospital must demonstrate that staff receive regular supervision, appraisals and team meetings.
- The hospital must demonstrate that all staff can act in an emergency and be able to use ligature cutters and the defibrillator and f have had training in life support.
- The hospital must demonstrate that it has effective ways to assess, monitor and mitigate risks relating to the health, safety and welfare of patients, the environment and service delivery.
- The hospital must demonstrate that staff know how the MCA and DoLS apply to the patient group, and detailed best interest assessments are carried out.
- The hospital must demonstrate that it has reviewed restrictive practices. Where stable doors are locked and the patient not free to leave the seclusion policy is implemented.
- The hospital must provide adequate space for the storage of equipment and for staff facilities.
- Patients have the option to meet as a group or meet privately with clinicians away from their apartment.
- The hospital must demonstrate involvement of patients and carers in their communication, health and care plans. Plans must reflect realistic goals towards discharge.
- The hospital must demonstrate it is using a range of communication tools and formats to engage with people with limited verbal and reading skills.
- The hospital must provide enough sessions for the clinical team to undertake all the work required for multi- disciplinary working such as ward rounds, one to one work with patients, audits, CPA and administration.
- The hospital must provide for therapeutic leave for patients who have authorised leave and consider ways in which patients can make links with their local community
- The hospital must provide a range of therapeutic, social, educational and leisure activities for the rehabilitation of the patient group.

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Bestwood

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bestwood Hospital	Bestwood Hosptial

Mental Health Act responsibilities

- Nottinghamshire Healthcare Foundation Trust provided the Mental Health act monitoring and administration through a service level agreement. There were no audits to demonstrate that MHA was being applied correctly.
- One medication chart did not have the treatment certificate attached with it. This meant that staff would not know if there was compliance with the treatment certificate or the legal authority under which the medication was being given.
- The MHA code of practice was not available to staff to refer too.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Professionals who visited told us that they had recommended that staff had more information on the MCA as they needed to have a better understanding.
- Staff we spoke to did not have an understanding of the MCA. Staff did not know what DoLS was and if it applied to any of the patients.
- Staff were not involved in capacity assessments. We saw an assessment of capacity relating to insulin for one patient which lacked detail.

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

Summary of findings

We found services were not safe because ;-

- The management had no clear processes of checking whether safe practice was happening due to lack of ways to monitor performance.
- Ligature audits had not been completed and not all staff had been trained in the use of a ligature cutter in an emergency.
- Health and safety audits had not been completed.
- Not all staff had been trained to use the emergency defibrillator in an emergency.
- Staff alarms did not work in the outside area of the hospital. This affected patients going out in the area.
- There was inadequate storage space for mops. buckets and washing machines. Patient medication was stored in two areas.
- Staffing levels impacted on patient activities and leave. Patients had very few activities and lack of transport affected going out into the community. One patient had not been out for two weeks, and another not at all.
- There were 70 incidents reported by staff. Staff knew how to report safeguarding's. Due to the lack of monitoring processes there was lack of assurance as to whether all incidents and safeguarding's were reported.

Our findings

Safe and clean ward environment

- There was a safe and secure environment policy which identified that the entrance to the hospital was gated and secured with a keypad. This meant that patients would not be able to access the community without authorised leave.
- Patients lived in self-contained apartments across two separate buildings; each apartment was fitted with a stable door which staff used to access the patient's apartments. Staff undertake administrative functions outside of the apartment environment. We witnessed staff sat outside of the rear stable door entrance which was locked. The front door and garden access to the apartments were unlocked.
- Each apartment contained a small garden area which had no furniture or features that would encourage patients to spend time there.
- The environment was generally clean and tidy. Due to assessed risk four patients do not have unsupervised access to the kitchens. Staff could not observe patients using the kitchen as kitchen doors did not have windows to look through. Washing machines were not available in the self -contained accommodation. Managers said this was a health and safety hazard and there were plans to have a washing machine in a separate building. This meant that patients were not being rehabilitated with everyday living skills of laundering.
- Three residents had accommodation directly off the "staff hub". The staff hub area was a small area consisting of utility facilities, a meeting room and a nurse's office, and a clinical room.
- The hospital did not have adequate storage space. There were several colour coded mops and buckets lined up outside in the open air. Mop heads were thrown away on waste ground. These were infection control hazards.
- The toilet and shower in the staff hub were clean. The shower had a washing up bowl in it and there was a mop stored there too. There was a shed outside which stored cleaning fluids, cloths and a mattress that was for throwing away. The shed was securely locked.
- Food hygiene certificate were completed by staff annually. Food and fridge temperatures were checked daily.
- The clinic room was small and cramped. The resuscitation bag was kept in the room. There were no records of the resuscitation bag being checked. It contained basic equipment and no emergency drugs. Staff were expected to dial 999 in the event of an emergency. A defibrillator was kept separately. Both bags were heavy and would need to be carried to the other apartments in an emergency. Staff had not practiced responding in an emergency and so had not timed how long it would take to carry the bags across to

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other apartments. All except three staff had undertaken first aid training. Only 16 out of 52 staff had been trained to use the defibrillator. There were plans to introduce basic life support training.

- We observed a petty cash safe box in the clinic room. It was left open because there was no key. There was no place to store it securely. A book recording the petty cash flow was up to date. Finance awareness training had only been completed by one member of staff.
- Nurses carried alarms; however these did no work in the car park areas in the hospital grounds. This was raised as an issue with the chief executive officer (CEO) of the company at a meeting on the 18 February 2015. This meant that some staff did not feel safe taking patients out into the grounds of the hospital. An environmental risk assessment had not been carried out to identify how this risk would be managed.
- All staff had completed mandatory health and safety training as well as moving and handling training.

Safe staffing

- Bestwood hospital employed seven whole time equivalent (WTE) nurses and had two WTE vacancies. There were six bank nurses who were contracted to the hospital and two agency nurses who were on three month contracts.
- There were forty three (WTE) nursing assistants.. There were three WTE nursing assistant vacancies. The hospital used a 12 hour shift pattern.
- Since September 2014 the OT, team leader and deputy team leaders had left. The staff reported to the hospital manager. Staff we spoke with reported that there had been staff shortages which had led to cancellations of patients leave and activities.
- Staff told us that the rota was not well planned. Sometimes there could be 13 staff on duty and other days seven. This was raised by the staff team with the CEO of the organisation on the 15 February 2015. We looked at the rota which showed there was between 10 to12 staff on the day shift and seven to eight on the nights during the week we inspected.
- The sickness rate was low at 1.3%. The turnover of staff was 22.8%. One carer told us that they were unhappy with the staffing since a high staff turnover from September 2014 had occurred. This meant that relationships and communications were not built effectively with patients. When carers asked questions of agency staff they received little information. This meant that carers were not being given up to date information about their relative.
- The nurse told us that they went to the patient's apartments when needed and to give medication. They spent time in the office to take calls and looked at care plans. They acted as named nurses for patients. The nurses met regularly with the team supporting the patient. There did not appear to be much direct care provided by the nurses.
- There was service level agreement with Nottinghamshire Healthcare Foundation trust to provide a consultant psychiatrist for two sessions a week. The service level agreement also provided for a speech and language therapist and a psychologist. Out of hours and annual leave medical cover was provided by Nottinghamshire Healthcare Foundation Trust consultants.
- Physical healthcare was provided by a local GP who also undertook annual physical health checks.

Assessing and managing risk to patients and staff

- A suicide prevention policy was in place and a ligature risk reduction policy. Apartments were risk assessed for individual patients prior to admission. However no ligature risk audits had been undertaken on an annual basis. One patient was placed in an apartment with padded walls and floors throughout. This padded apartment had been a personalised design for a particular patient who did not arrive. We did not see risk assessments that warranted a padded environment for the patient residing there.
- There were 15 out of 52 staff who had not completed their mandatory training for ligatures knives which would be used to cut ligatures in an emergency.
- The risk assessment and management plan (RAMP) tool was used for assessing every patient. Risk assessments were discussed at ward round meetings. We sampled five risk assessments and risk plans, four of these were up to date and linked to the care plans. One had not routinely been reviewed and linked to the care plan. Staff we spoke with said there was a positive risk taking approach with patients where appropriate. Two written case studies showed the improvements that had been made compared to their previous placements.

Are services safe?

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- There were restrictive practices. Staff told us that patients could request their stable doors to be opened or closed. We observed patients were behind the doors of their apartments and could not leave their accommodation. One relative informed us that the stable door was always locked whenever they visited. Stable doors were used by staff to keep patients within their apartments. The bottom half of the stable door were closed constantly for two residents and staff talked to them over the door. Staff contacted the nurse in charge to ask if the stable door could be opened or closed. The nurse made the decision depending on the mood of the patient. We were informed that no one had technically been secluded. We were concerned that if patients had to ask permission for the stable door to be opened that this was seclusion and the seclusion policy was not being followed. We were informed that the patients could open their doors into their gardens. The use of restrictive practices was discussed in the patient ward rounds. Support staff told us that they had not been informed about the DOH publication "Positive and proactive practices on the use of restraint".
- One patient had a budget for themselves and food. Staff were not able to explain whether a best interest decisions were in place regarding money and how it was spent was in place. A finance policy was in place to manage patient's finances, it was not clear who audited this, and no audits were available.
- There was a closed circuit television and surveillance policy (CCTV). Covert surveillance had been applied for one patient. This approach had been discussed in the care programme meeting. There was a clear plan in place and it had been reviewed. In line with the careplan the surveillance had been stopped two days before our visit.
- There were 17 restraints reported as incidents, none of which were in the prone position.
- One relative told us that they were pleased that restraint was not being practiced. Staff told us they had received restraint training and used walking holds, getting heads up and supine holds and breakaway techniques. Care records sampled showed that holds were used used daily. We observed one patient who was linked by their arms to two staff , when they walked into their apartment. The patient did not object to this, however when we talked to staff about it they did not appear to recognise this as restraint. All staff had completed the mandatory three day training . 15 staff had not undertaken there annual update training.
- Due to the building design and facilities it could be viewed that patients are being cared for in longer term segregation in the community. Patients were there because they struggled in settings where they shared with others or required an environment that promoted self-care and independence. The hospital had a longer term segregation policy for those patients who would pose a risk of physical or psychological violence to themselves or others. We were informed that none of the patients were in seclusion or long term segregation. However many of the stable doors were locked.
- Staff raised concerns at their meeting with their CEO in February 2015 that the documentation for new patients did not adequately detail triggers for disruptive behaviour.For example one patient had full access to the staff area so had unrestricted access to knives and a kettle which were serious risks.
- Pharmacy support was from a local chemist to provide prescriptions. No pharmacy audits were undertaken. The hospital was exploring other options for pharmacy support.
- All staff had undertaken "supporting medicines" mandatory training. Nurses gave out the medications to patients in their apartments. Some medicines were kept in the patient's apartments and some medications in the clinical room; this was due to lack of storage space. Medication stock was locked amd it was checked and signed by nurses.
- No rapid tranquilisation had been used from April 2014 to the date of the visit. Medication that was given as required (PRN) was discussed at ward rounds. PRN medication was given 180 times to one patient, 25 times to another patient and five times to a third patient. PRN medication was reviewed at ward rounds. PRN medication is given when required and should not be given as a regular dose unless it is prescribed as such.
- There was a visiting policy which also stated the procedures used before children visit. Half of the patients did not have any regular contact with family or friends. For these patients building up community links would be very important.

Are services safe?

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- All staff had received safeguarding training as part of their mandatory training. However 28 staff needed to complete their annual refresher training.
- Staff reported safeguarding incidents to the nurse in charge. Staff gave examples of when a safeguarding concern would be raised. During out of hours the on call manager would be informed. The managers would inform the local authority safeguarding team. Staff did not appear to make direct referrals without going through the person in charge.
- We saw three safeguarding referrals that had been made. These involved one patient and related to psychological abuse, financial irregularities and threats of punishment. Police were informed as well. We were provided with a note of learning from safeguarding incidents in July 2014. The learning points related to ensuring that all staff were aware of what support plans and individual risk management plans were in place, and were followed. This was to be supported through supervision, training and team meetings. We were not assured that this was achieved due to the lack of supervision, training and team meetings. We did not receive any lessons learnt from other serious incidents that had occurred.

Reporting incidents and learning from when things go wrong

- There were 70 incidents reported from April 2014 to February 2015. The incidents related to five patients. One patient had 31 incidents recorded, another 15 and one patient had 11.There were five serious untoward incidents.
- Incidents were reported to the registered manager (RM) and if the registered manager was not there it would not be dealt with. Mangers reported that there was a need to improve the completion of incident forms and to store the forms on a new electronic system to be introduced. Team leaders would be responsible for recording the information electronically.
- Staff gave examples of when they would report an incident. A patient had tried to use scissors on their nails when a chiropodist would have been more appropriate. A patient had absconded and this was investigated. This resulted in increased security checks.
- Staff told us that debriefings following incidents did happen. An example was given that during school holidays a fast food restaurant would be avoided, because it distressed a patient.

Are services effective?

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

Summary of findings

We found services were not effective because;-

- Staff were not aware of patients level of reading. Communication profiles were either not in place or the plans lacked enough information. This meant that assessments were not detailed about individual needs and the plans that would support them.
- No clinical audits were undertaken which meant that the team did not have information to improve their effectiveness. .
- Staff received little or no managerial and clinical supervision so that they could be supported in reflecting on their practice.
- The psychiatrist, speech and language therapist and psychologist were contracted for sessional work. This meant there was little time available to undertake weekly reviews of all patients and work with individual patients. Support workers were not involved in the clinical team meetings. The functional analysis of behaviour and how this could affect treatment were not understood by staff. Staff were not clear what they should do following clinical meetings or psychotherapy sessions with patients.

Our findings

Assessment of needs and planning of care

- We asked how many of the patients could read. We were concerned that staff did not know how many. This indicated that assessment of individual needs was not understood in detail. This would affect communication and the format of information being shared with patients.
- Communication plans were present. However for one patient, the plan was poor as it did not give enough information. One patient did not have a communication profile in place. One patients communication plan was out of date.
- We did not see behaviours being recognised as a form of communication by patients.
- The risk plans were detailed however there were two that had not been signed. The risk plans did not have patient involvement and were not written in a format that patients could understand.
- A GP visited to provide treatment for physical health problems. Physical healthcare assessments were not documented in the care notes of patients.
- Records showed that one patient had lost a stone and half in weight. There was no assessment as to the reason why.There was no action plan to support this.
- Care records were not person centred and were not updated. Daily records were made although two records did not appear to have been reviewed regularly. Two patients had only received two care programme approach (CPA) meeting in two years, and one patient had not had any. CPA should be undertaken regularly.
- Information was easy to access . Care records were paper based. Bank and agency nurses had access to the hospitals computers to make notifications.

Best practice in treatment and care

- Staff stated they used the national institute of clinical effectiveness guidance (NICE) for medication, autism and accessing the community. No audits had been undertaken to demonstrate compliance with NICE guidance.
- The hospital was aware of the need to conduct cardio metabolic assessments for patients with schizophrenia and provided blood tests results. We saw that they had and noted the reasons why blood pressure, body mass index and glucose monitoring had not occurred for one patient.
- Medication cards reviewed were signed and dated and antipsychotic drugs were within the British National Formulary limits.
- There was access to psychotherapy for individual patients. There was no private space for the psychotherapist to work with the patient. Sessions had to be done in the patient's apartment. This was not therapeutic because the patient had no way of leaving their emotional discussions behind. We noted that this could have affected the behaviour of one patient.
- Patients were registered with the GP and attended hospital appointments for physical health problems.
- Health of the Nation Outcome Scales (HoNOS) were used to look at the patient's progress. . Four records showed this was done six monthly. Staff told us that there had been a significant reduction in HoNOS showing improvements in outcomes recently.
- The patients in the hospital had challenging behaviours and progress was noted. One patient was having

Are services effective?

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structured supported walks. Another was going out shopping, to the banks, making changes to the apartment and building positive relationships with staff. The hospital provided two case studies to show the progress made since the patients had left their previous placement.

- Staff did not participate in audits. Manager confirmed no audits had been done. This meant that managers had no oversight of the quality of practice taking place. Staff did not have information to support improvements in practice.

Skilled staff to deliver care

- A consultant psychiatrist, SALT and psychologist were provided through a service level agreement with Nottinghamshire Healthcare Foundation Trust for approximate a day per week. Occupational therapy was provided on a sessional basis for some patients, and for rehabilitation unit there appeared to be limited input.
- Supervision was not given regularly. Managers confirmed this. We looked at a personal file which showed one supervision record. The record stated that little induction had been given. It was the first supervision session since starting in 2014. The staff member had missed shifts because they were not informed of being on the rota. Their mentorship had not been arranged. Some staff we spoke with had not received supervision for a year or more.
- The support workers training did not reflect the knowledge and skills required to meet the complex needs of the patient group. They were the staff in most prolonged contact with the patients. Ten support workers out of the 43 had NVQ qualifications in health and social care.
- There was a mixed view about the induction training offered. Two support workers described their induction training and the three day restraint training as not very good. They reported learning took place by shadowing other support workers so that they learnt as they went along. Two other support workers described their training as good.
- We saw information that showed disciplinary procedures were implemented for staff misconduct.

Multi-disciplinary and inter-agency team work

- We found there was further work to be undertaken to develop an effective clinical team. The clinical team of consultant, psychologist, SALT, nurse and manager met weekly to discuss half of the patients. They discussed risks, incidents, safeguarding and treatment. The notes of the clinical team were written and shared with the rest of the staff. Support workers were not included in the meetings. A visiting professional had requested pharmacy and OT input to be considered to ensure effective integrated multi-disciplinary input. The team did not have sufficient time to discuss everyone at the clinical team meeting as time was required to prepare for tribunals and CPAs.
- The cause of incidents, triggers to behaviours and approaches to use to engage patients were discussed with nurses. Visiting professionals observed that approaches to engaging people were not consistent. We saw behavioural support plans, however support staff we spoke with told us they had not heard of these. A lessons learnt outcome in 2014 said that behavioural support plans should be supported and implemented. This meant that behavioural support plans were not being effectively promoted and implemented.
- An autism advisor had visited and given advice to the two staff who supported the patient. This learning was shared by writing in a communication book and was not discussed with the whole staff team. This meant that there was a risk that specialist advice was not captured in the case records of patients and consistently applied in the care of patents.
- There was psychologist input However, staff told us that the types of treatment were not understood by staff. Staff were not able to state what they were expected to do after a psychology session to continue the benefits of it for the patient .

Adherence to the MHA and the MHA Code of Practice

- We were informed that Nottinghamshire Healthcare Foundation Trust provided the MHA monitoring and administration through a service level agreement. There were no audits to demonstrate that MHA was being applied correctly.
- One medication chart did not have the treatment certificate attached with it. This meant that staff would not know if there was compliance with the treatment certificate or the legal authority under which the medication was being given.
- The MHA code of practice was not available to staff to refer too.

Good practice in applying the MCA

Are services effective?

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

- Professionals who visited told us that they had recommended that staff should have more information on the MCA as they needed to have a better understanding.
- Staff did not have an understanding of the MCA and did not know what DoLs was and if it applied to any of the patients.
- Staff were not involved in capacity assessments. We saw an assessment of capacity relating to insulin for one patient which was not detailed.

Are services caring?

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

Summary of findings

We did not find services to be caring because;-

- Patients did not have copies of their care plan. The needs of people were complex and we did not see innovative ways that people were involved in their care planning. Care plans were not recovery orientated.
- One patient was sleeping on the sofa as a habit. They were involved in planning the décor and new bedding for their bedroom. We were concerned that the bed was not made up so a care plan to promote sleeping in a bed could be promoted.
- No surveys or community meetings took place to invite feedback on the service from patients or carers.
- Not all carers felt they were involved with the care of their relative, or were provided with information.

Our findings

Kindness, dignity, respect and support

- Staff treated people with kindness and respect. However there appeared to be a traditional culture in which staff did not analyse the behaviours of patients and fully utilise approaches that would support their rehabilitation. Safeguarding and disciplinary incidents had raised issues about staff attitudes towards patients. Visiting professionals reported the need for a change in culture.

The involvement of people in the care they receive

- We saw a communication plan that contained information which said the opposite to what staff had told us about a patient. It gave no information about the way the person communicated and should be communicated with.
- Patients did not have copies of their care plan. The needs of people were complex and we did not see creative ways in increasing the chances of getting people involved in their care planning. Care plans were not recovery focused. We spoke to three carers. One carer found it difficult to visit due to the long distance. However was happy with the care and communication given. The main concern was the lack of clarity of the care pathway for the patient when they were ready for discharge from hospital. One carer said they were not engaged in the care and treatment plans for their relative. They were unhappy about the lack of communication from the hospital and felt isolated. They were given minimal information. No information about CPA or ward rounds was given. No information about how the patient had spent their day was given. They were allowed one phone call with the hospital manager. One carer was concerned about the lack of activities provided.
- One patient slept on a sofa as a habit. The were involved in planning the décor and new bedding for their bedroom. Their bed was a PVC covered single bed which was unmade. We were concerned that this did not encourage the implementation of their care plan to use a bed.
- One patient had a budget for themselves and food. A shopping list was made and a driver and member of staff went out to buy food on Mondays. Shopping lists were made at the weekend. We were concerned that the patient was not involved in going out and buying the food as part of their rehabilitation process. We were concerned that the patient would ask for food when they were ready, rather than be encouraged to have a mealtime routine.
- An advocate visited the patients once every week. They had the same advocate from the commissioned organisation. Staff involved the advocate in any issues related to patients. The support workers had recently asked for a planning meeting for a patient and the advocate was invited. The advocate was able to raise issues with the managers and felt listened to.
- Patients did not have advance decisions in place.
- No surveys or community meetings took place to provide feedback on the service from patients or carers.
- Patients and carers were not involved in the decisions about the hospital service such as involvement in staff interviews.

Are services responsive to people's needs?

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

Summary of findings

We did not find services to be responsive because;-

- Discharge planning was not well recorded. Two patients had been ready for discharge last year and were still awaiting placements. This meant that they were not able to live in a less restrictive environment.
- There was limited OT input and very few activities for patients to do. There was no transport to take people out and this meant they were isolated from the wider community.
- Communication aids and information in formats accessible to patients were not being used. Behaviours as a form of communication were not well understood by all staff.
- There were no complaints for April 2014 to February 2015. No audits had been done on the complaints system.

Our findings

Access, discharge and bed management

- Access to hospital beds was through referrals to the psychiatrist and hospital managers. The psychiatrist and another member of staff undertook the assessments. There was an Eden central panel that discussed the referrals. There were two patients who had been placed outside of the area they came from.
- The provider did not have a clinical director that had meetings with the clinical team to discuss the purpose, vision and direction of the hospital. The clinical team held an oversight meeting in the absence of this.
- There was a lack of discharge planning observed in the case records. The patient's pathway of care was not clear following their placement at the hospital. Two patients were described as "more than ready for discharge "to another facility since September 2014. Discussion was taking place with clinical commissioning groups and local authorities. The effect of this delayed discharge was that patients remained away from the areas they came from; they had limited choices about where they would next live and were not living in the least restrictive environment in terms of the progress they had made.

The ward optimises recovery, comfort and dignity

- There were no activity rooms for patients to meet and use on the site. Nor was there encouragement for people from the apartments to meet together. Managers informed us that a portable cabin had been ordered so that staff had a rest room to use, and separate meeting rooms.
- There was a visitor's policy in place. Not all patients had friends and family, we did not see how these patients made links with the community as part of their rehabilitation.
- People were able to personalise their bedrooms. They were able to store their possessions in their apartments. Some personal items had been given to staff to store by patients.
- Food was prepared in the apartments with staff supervision. Patients had access to hot drinks and snacks in their apartments as required.
- Patients had limited activities to do. We saw patients lying on sofas, one patient was watching a DVD they had chosen. Some patients walked in the grounds escorted. The lack of transport meant that one patient had not been out into the community for two weeks, and another had not been out at all. There was very limited OT input.
- Visiting professionals said that more meaningful activities were required for the patients.
- One carer told us they were disappointed with the lack of activities and expressed concern about the isolation of their relative. They said they observed staff talking over the locked stable door, there was no outdoor activities such as swimming, walking with family and friends or behavioural therapy.
- One family carer described a lack of engagement. This could be detrimental to the wellbeing of a person who has limited or no verbal communication, as family are likely to have considerable knowledge of needs, preferences and behaviours.

Meeting the needs of all people who use the service

- We did not see that information had been provided in a variety of formats or communication aids used to meet the needs of patients. One patient needed glasses but would not wear them. We asked what staff would do to help in other ways. No adjustments had been made, for example to increase the size of pictures or information

Are services responsive to people's needs?

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

and staff didn't know what the nature of the visual impairment was. Staff thought one patient might read because they sometimes gave them a newspaper for the pictures in it. There was a lack of consideration of what this might mean in communication and passing on information. Staff gave an example of how one patient used books in an unusual way. Books were stocked up when relatives visited. There was a lack of consideration of how this could be combined into the person's activities and built upon.

- One patient we spoke with appeared to use "rote phrases" and staff didn't appear to have considered this and what the person might mean and how best to approach these.
- One patient went to bed at 5pm daily and woke up in the middle of the night and might ask for breakfast. Staff gave this, however previously this had not been allowed. There was a care plan to work with the person about using a bed.
- The staff hub environment was noisy. One patient spent the majority of the day shouting, banging and throwing things. On their door there was a sign saying "Please keep noise to a minimum". We observed at different stages of the day a lot of staff in this area, at one point we counted 10 staff, with lots of different conversations going on. This level of noise impacted upon patients who needed a quiet calm environment.

Listening to and learning from concerns and complaints

- The hospital managers confirmed there were no complaints received from April 2014 to February 2015.
- Patients were able to say who the person in charge was if they wanted to raise an issue. Staff reported they would talk to the patient and try and resolve issues locally, if this was not possible they would report the issue to the manager or CQC.
- There was a hospital audit tool for complaints, concerns and compliments. The audit had not been completed

Are services well-led?

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

Summary of findings

We did not find services well led because ;-

- There was no clear vision of the purpose of the hospital. The principles of supported living were being applied in a hospital setting which managers found created difficulties.
- The governance arrangements were poor. We were given a folder of audit tools none of which had been implemented.
- There was no performance management information provided to the staff to monitor performance in relation to supervision, appraisal, training, incidents, safeguarding and staffing.
- The hospital team did not have team objectives. The lack of learning from audits, complaints, and information about performance did not inform people of what needed to improve. This in turn did not support individual managerial and clinical supervision sessions.

Our findings

Well Led

Vision and values

- Staff wanted to deliver the principles of supported living in a hospital environment to detained patients. The managers agreed that this had been a challenge in trying to manage the model of care.
- The hospital team did not have team objectives. The lack of learning from audits, complaints, incidents and information about performance did not inform people of what needed to improve. This in turn did not support individual managerial and clinical supervision sessions.
- The CEO and senior staff had visited the hospital and met with staff on the 18 February 2015. The staff raised many issues. They were concerned that the patient group was different to the original one that they had been given. They were concerned that the patients were placed at hospital without clearly defined outcomes so teams could work to common goals. This meant that there were no clear vision and values being shared. The minutes of the meeting with the CEO identified that the concerns raised by staff would be reviewed and action taken.

Good governance

- The governance systems were poor. We were given a folder of audit tools none of which had been implemented. These were for ;-clinical governance review ,service user support and involvement, protecting from harm, service delivery and staffing, complaints, surveys for staff, carers and patients,and monthly service user reports.
- There was no performance management information provided to the staff to monitor performance in relation to supervision, appraisal, training, incidents, safeguarding and staffing.
- Nurses said they spent more time in the office looking at care plans, answering the phone and giving out medications. There did not appear to be much time spent in direct care activities.
- Not all staff had a good understanding of the MCA, DoLS and best interest decisions.
- There was no hospital risk register. Managers informed us that it was in the form of an action plan. We looked at the action plan and found that the action plan did not make reference to person centred planning. It did not link the external work of the visiting clinical team to the skills and requirements of the care staff.There was no clear plan of rehabilitation programmes leading to discharge and no mention of on-going comprehensive reviews of care plans. Risks were not clearly identified particularly in relation to their operating model.

Leadership, morale and staff engagement

- There was a lack of managerial and clinical leadership. Staff at their meeting with the CEO in February 2015 highlighted their concerns that there was no management structure, clear lines of accountability and responsibility. Team meetings had not been happening. Staff rotas were poorly planned. Personal alarms in the car park did not work. Support staff wanted to be present at the weekly ward rounds to contribute and to understand what they needed to do.

Are services well-led?

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

- Staff and minutes of the meeting in February 2015 with CEO stressed issues around the staff payroll. Staff reported that that their payments were not always correct and they did not receive payments on time. Managers confirmed this was the case.
- Staff knew how to raise concerns and told us that if the situation arose they would use the whistleblowing, harassment and grievance procedures.
- Minutes of the meeting with the CEO showed the senior management took seriously issues such as racism and encouraged the staff to contact the CEO directly.

Commitment to quality improvement and innovation

- The hospital had developed links with the national development team for inclusion, and for an extension of the excellence in locked rehabilitation project in the East Midlands. This was to form peer reviews and share good practice. A peer review of the hospital had not occurred.

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 **9.**—(1) The care and treatment of service users must— (a)be appropriate, (b)meet their needs, and (c)reflect their preferences. (2) But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11. (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a)carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; (b)designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; (c)enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment; (d)enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible; (e)providing opportunities for relevant persons to manage the service user's care or treatment; (f)involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user's care or treatment;

This section is primarily information for the provider

Requirement notices

(g)providing relevant persons with the information they would reasonably need for the purposes of sub-paragraphs (c) to (f);

(h)making reasonable adjustments to enable the service user to receive their care or treatment;

(i)where meeting a service user's nutritional and hydration needs, having regard to the service user's well-being.

How the regulation was not met;-

- Communication plans were did not provide enough information about the communication needs of people. Staff were not aware of whether patients could read. Communication aids and easy read information were not available so that patients could be given information in an accessible format.
- There was lack of carer and patient involvement in the care plans.
- patients did not have private space away from their apartment to have psychology or psychotherapy sessions.
- One patient had lost half stone and there was no assessment or plan to support the persons nutritional and hydration needs

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 **12.**—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a)assessing the risks to the health and safety of service users of receiving the care or treatment; (b)doing all that is reasonably practicable to mitigate any such risks; (c)ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

This section is primarily information for the provider

Requirement notices

(d)ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

(e)ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

(f)where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

(g)the proper and safe management of medicines;

(h)assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

(i)where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

How the regulation was not met;-

- No health and safety audits had been undertaken.
- Ligature audits had not been completed. Not all staff had completed training on using ligature cutters. Not all staff had completed training in using a defibrillator.
- A treatment certificate was not linked to the medication chart of one patient
- No pharmacy medication audits took place. Patients medication was stored in two places due to lack of storage space.
- Mops and buckets were stored outside. One mop and bucket was in a communal shower room.
- There was lack of recording of discharge planning. Two patients had delayed discharges because suitable placements had not been found. Both patients had been ready for discharge since September 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **A warning notice was issued in relation to regulation** **17.**—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a)assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (d)maintain securely such other records as are necessary to be kept in relation to— (i)persons employed in the carrying on of the regulated activity, and (ii)the management of the regulated activity; (e)seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

This section is primarily information for the provider

Enforcement actions

(f)evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—

(a)a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and

(b)any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.