# Chesterholme

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

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

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

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

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

# Summary of findings

## Overall summary

We rated Chesterholme Hospital as good because:

- the hospital was visibly clean with well-maintained furnishings
- staffing levels were appropriate and met the needs of the patients
- staff mandatory training rates were good and staff had access to extra relevant training specific to their role
- assessment of patients' care needs were comprehensive and completed in a timely manner including comprehensive risk assessments
- there was good practice in the prescribing of medication
- staff used a positive behaviour support model and patients had appropriate access to psychological therapies
- healthy meals were provided and drinks and snacks were available 24 hours a day
- there was a good working relationship between the nursing staff and staff of other disciplines
- patients said that staff supported them and we saw positive interactions, with staff treating patients with dignity and respect
- patients told us they had seen, had signed or were involved in developing their care plans
- patients had the opportunity to have support from an independent advocate
- patients and their carers could make suggestions about the hospital to help it improve
- patients were involved in regular community meetings on the ward
- the hospital optimised the recovery, comfort and dignity of patients
- patients had the opportunity to take part in activities daily, including at weekends, either in the hospital or in the community
- managers and staff listened to patients' concerns and complaints and responded to them
- the hospital was very well led at a local level by the hospital manager, who was visible and available most days
- the hospital had good clinical audit and governance systems and processes to support the provision of a high quality service.

However, there was no female-only lounge despite the hospital being recently refurbished. Staff did not record the observations of patients as recommended in the observation policy. Patients were subject to restrictive practice regarding observations in the bedroom area. Equipment in the clinic room had expired and was unsafe for use. There was limited speech and language therapy. Care plans and risk management plans were not always fully completed. Some patients had been in the hospital for long periods with no firm plans in place for their discharge. The hospital was working with local area commissioners, to source and develop appropriate placements but progress was slow due to a lack of appropriate provision in the community.

# Summary of findings

## Contents

Good

# Chesterholme

**Services we looked at**

Wards for people with learning disabilities or autism

# Summary of this inspection

## Background to Chesterholme

Chesterholme hospital is for adults of working age with a learning disability. It can accommodate 16 people, male or female. The hospital has patients who are detained under the Mental Health Act 1983 and informal patients (there with their consent). At the time of inspection there were three patients detained under section 3 of the Mental Health Act and five who were subject to Deprivation of Liberty Safeguards (DoLS), under the Mental Capacity Act 2005. This means that their freedom was restricted in the minimum way necessary for their safety and wellbeing. The hospital also has a step down facility for patients who require less intensive support. At the time of our inspection, there were 11 patients within the hospital site.

The last Mental Health Act review was on 17 February 2015. The reviewer made recommendations and Chesterholme Hospital responded in July 2015 with an action plan of how improvements would be made. We found that the improvements had been made at the time of our inspection. Chesterholme has been registered since September 2013 and has not been inspected since registration.

The registered manager was Mike Neville and the nominated individual was Andrew Murray.

## Our inspection team

The inspection team was led by two CQC Inspectors, Clare Fell and Victoria Anderson, two learning disability nurses, and an expert by experience, supported by a support agency worker. (An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them).

## Why we carried out this inspection

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

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information, and sought feedback from patients.

During the inspection visit, the inspection team:

- visited the hospital site, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the manager of the hospital
- spoke with eight other staff, including the activities coordinator, a doctor, a healthcare assistant, two qualified nurses, an occupational therapist, a psychologist, and a psychology assistant.

We also:

# Summary of this inspection

- looked at six treatment records of patients
- carried out a specific check of the medication management within the hospital
- spoke with two carers
- looked at Mental Health Act (MHA) documentation to see if staff had followed the MHA Code of Practice
- looked at policies, procedures and other documents relating to the running of the service.

## What people who use the service say

We spoke with five patients at Chesterholme hospital and observed various activities taking place. All five patients told us that the staff were kind and treated them with respect and dignity. The staff knocked on their bedroom doors before they entered. Patients told us that they felt safe, listened to, and that staff responded to incidents.

Patients told us they were involved in community activities and encouraged to stay in contact with family and friends.

Patients told us they had been orientated to the hospital and provided with information about their care and treatment. Five patients told us they had sight of, or had signed, or been involved in their care plans. Three patients told us they attended and contributed to multi-disciplinary meetings.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Requires improvement

We rated safe as requires improvement because:

- there was no female-only lounge
- there was no recording of patient observations as recommended in the observation policy
- equipment in the clinic room had expired and was unsafe for patient use
- staff were using restrictive practices for observations in the bedroom area. Staff were reliant on bedroom door alarms for all patients regardless of risk profile or observation level.

However, the hospital was visibly clean, with well maintained furnishings. Staffing levels were appropriate and met the needs of the patients. Mandatory training rates were good. Comprehensive risk assessments were completed on admission and updated as necessary.

### Are services effective?

Good

We rated effective as good because:

- assessments of patients' care needs were comprehensive and completed in a timely manner
- there was good practice in the prescribing of medication
- patients had appropriate access to psychological therapies
- patients were supported to attend a wide range of community activities
- staff used a positive behaviour support model
- staff had access to extra relevant training specific to their role
- there was a good working relationship between the nursing staff and staff of other disciplines

However, there was limited speech and language therapy available to patients who required it which meant that their recovery progress was slow. Patients care plans and risk management plans were not always fully completed and did not always correspond to the risks identified in the risk assessments.

### Are services caring?

Good

We rated caring as good because:

- patients said staff supported them and we saw positive interactions, with staff treating patients with dignity and respect
- patients told us they had seen, had signed, or were involved in developing their care plans

# Summary of this inspection

- patients had the opportunity to have support from an independent advocate
- patients and their carers could make suggestions about the hospital to help it improve
- patients were involved in regular community meetings on the ward

## Are services responsive?

Good

We rated responsive as good because:

- there were systems in place to assist with the access and progress of patients
- the wards optimised the recovery, comfort, and dignity of patients
- healthy meals were provided and drinks and snacks were available 24 hours a day
- patients had the opportunity to take part in daily activities, including at weekends, either in the hospital or in the community
- managers and staff listened to patients' concerns and complaints and responded to them.

However, some patients had been in the hospital for long periods with no discharge plans in place. The hospital was working with local area commissioners but progress was slow due to a lack of appropriate provision in the patient's home areas.

## Are services well-led?

Good

We rated well led as good because:

- the manager, who was visible and available most days, managed the hospital well at a local level
- the service had been proactive in capturing and responding to patients' concerns and complaints
- the hospital had good clinical audit and governance systems in place and processes to support the provision of a qualitative service
- the hospital manager reviewed and increased staffing to meet patients' needs. Most staff had completed their mandatory training.

# Detailed findings from this inspection

## Mental Health Act responsibilities

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

Staff were trained in the MHA and had a good understanding of the code of practice and guiding principles. We found that 97% of staff had completed their annual mandatory training in the Mental Health Act and staff we spoke with showed a good knowledge and understanding of the act.

The Mental Health Act monitoring visit in February 2015, found that consent to treatment and capacity assessments in relation to capacity to consent were adhered to and that all documents in relation to consent to treatment were present and correct. Detained patients were read and explained their rights by nursing staff on a monthly basis. We saw easy-read leaflets relating to mental health rights, which were accessible to patients.

A central team, based at another location, was available to give advice and support in relation to the MHA. Staff we spoke with described a Mental Health Act administrator who was very knowledgeable and helpful, and that booklets were available in the nursing office to help guide staff.

During our inspection process, we examined the MHA audits and found these to be up to date and correctly applied.

Patients had regular access to an independent Mental Health Act advocate, who was employed by Voiceability and visited the hospital weekly. Staff we spoke with were aware of the advocacy role and knew how to make referrals.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy-one per cent of staff were trained in the Mental Capacity Act 2005. The hospital manager informed us that the remaining staff have booked onto a course and were waiting for training dates. Staff we spoke with demonstrated a good understanding of the Mental Capacity Act (MCA) and its application.

There were five patients subject to Deprivation of Liberty Safeguards, (DoLS) applications. The safeguards are to ensure that restrictions on the freedom of patients are the minimum necessary for their safety and wellbeing.

We found that for those people with impaired capacity to make decisions about their care, their capacity to consent had been assessed and recorded appropriately. Best interests meetings were held and this had been documented in patient care records and was decision-specific.

The hospital manager informed us that information regarding DoLS was stored in the office for staff to refer to if necessary, we saw evidence of this when reviewing files.

We also saw easy-read leaflets, which included, “making decisions” and “have your say,” which were easily accessible for patients and carers. Staff informed us that they regularly explained information relating to the MCA to patients in patient-led forums.

The provider has completed its own audit into the use of the Mental Capacity Act. These audits completed in June 2015 confirmed that the records were 99% compliant in all areas of the MCA. In 2014, the compliance rate was 100%.

## Overview of ratings

Our ratings for this location are:

# Detailed findings from this inspection

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Wards for people with learning disabilities or autism | Requires improvement | Good | Good | Good | Good | Good |
| Overall | Requires improvement | Good | Good | Good | Good | Good |

Good

# Wards for people with learning disabilities or autism

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Are wards for people with learning disabilities or autism safe?

Requires improvement

### Safe and clean environment

The hospital layout did not allow easy observation of patients in all areas. Patient areas were over two floors and there were many corridors. However, appropriate staffing levels mitigated some risks associated with observation of patients. We found ligature points in patients' ensuite bathrooms and other rooms such as the pamper room. Taps were not of the anti-ligature design in the bathrooms and decorative netting was used in the pamper room which was also a ligature risk. Risks were mitigated by individual patient risk assessments regarding their risk of ligature. During our visit, none of the current patients were identified as being at risk of harming themselves using a ligature. Staff told us that if a patient was at risk in relation to self-harm with ligatures, then their environment would be adapted and risks removed to mitigate this. Ligature points had been identified and placed on the hospitals risk register; we also saw evidence of regular audits and a ligature policy. A plan of work to replace any ligature points with anti-ligature designed fitments had been identified by the Senior Management Team. This work was due to be completed by 31 December 2015.

There were six lounges, five in the main hospital building and one in the annex; however, none of these were designated as a female-only lounge. The hospital underwent refurbishment in 2011 and further work was completed in the following years. This meant that the hospital was not meeting the Department of Health safety, privacy and dignity in mental health units guidance on same sex accommodation.

The clinic room was visibly clean, tidy and well arranged. A blood pressure monitor and weighing scales were available. The room was equipped with accessible resuscitation equipment, which had been checked and recorded daily. Emergency drugs were available and in date and checked on a daily basis. The medicine cupboard was well arranged with appropriate labelling and was secured safely to the wall.

However, a number of items were found to have expired, these included ,

- the electrical safety test for the suction machine
- the surgical facemask
- the emergency eyewash spray (one had expired, one was missing)
- the defibrillator battery had no expiry date written on it
- the sharp object container did not indicate the date it was assembled or by which staff member.

These discrepancies were brought to the attention of the manager and rectified during the inspection.

All areas of the hospital were clean, bright and of good size. All furnishings were well maintained and in order. Cleaning records showed that the environment was cleaned on a regular basis. There were hand-washing facilities available for staff and alcohol gel was provided.

Good

# Wards for people with learning disabilities or autism

We saw evidence that regular environmental risk assessments had been undertaken. Where necessary items were placed on the hospital risk register. This allowed the senior management team to maintain oversight of any risks to patient safety.

All patient areas had nurse call alarms in place on the wall. Patient's bedrooms also had an alarm system to alert nursing staff if a patient was leaving their bedroom. This meant that all patients were subject to restrictive observation, which for some patients was unnecessary.

**Safe staffing**

Key Staffing Indicators

- Establishment levels: qualified nurses (WTE) was 8
- Establishment levels: nursing assistants (WTE) was 22
- Number of vacancies: qualified nurses (WTE) was 0
- Number of vacancies: nursing assistants (WTE) was 1
- The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in 3 month period was 0
- The number of shifts that have NOT been filled by bank or agency staff where there is sickness, absence or vacancies in 3 month period was 0
- Staff sickness rate (%) in 12 month period was 8
- Staff turnover rate (%) in 12 month period was 24

Staffing ratios were established using the provider staffing ladder, which matched occupancy levels with nursing staff numbers. The hospital manager explained that he also takes into account individual patient needs and is able to adjust staffing levels as necessary depending on the current need of patients without difficulty.

The hospital manager explained that during the day, there were usually one or two qualified nurses, working alongside at least five nursing assistants. During the night, this number falls to one qualified nurse, working with two nursing assistants. On checking with the staffing rotas and speaking to staff, we found this to be a true reflection of staffing levels.

Staff sickness and turnover rates were higher than the national average. According to the Health and Social Care Information Centre, (HSCIC), the average sickness rate for NHS staff in England was approximately 4%. The average turnover rate for NHS staff in England was approximately 10%.

We observed nurses and nursing assistants maintaining a visible presence in patient areas.

Patients had regular one to one time with their named nurse and this was evident in patient records. We found that escorted leave or activities were rarely cancelled due to staffing and that staffing in general was of a good standard to manage patient care safely.

The hospital had an on-call doctor system in place, where three doctors were on an out-of-hours rota to provide 24-hour care and treatment to patients.

Staff had received and were up to date with most mandatory training, with compliance at 92%. The hospital's target for mandatory training was 80%. We found that 97% of staff had completed their annual mandatory training in the Mental Health Act, and 86% of staff had completed their safeguarding training.

However, completion rates were below the hospital target for the following training,

- equality and diversity 74%
- mental Capacity Act/Deprivation of Liberty Safeguards 71%
- moving and handling 68%
- food safety 79%

Staff explained that they were booked onto training in the coming months and planned to be fully compliant with training by the end of the year. Staff received service specific training in relation to positive behaviour support, (PBS), and 100% of staff had completed this. However, staff were only required to complete this once and no refresher or updated training was available. Staff said they felt that this training should occur more frequently.

**Assessing and managing risk to patients and staff**

The hospital did not have a seclusion room and by reviewing the care records and speaking to patients and staff, we found that no seclusion took place in any other rooms.

There were 22 incidents of restraint recorded in the last six months, none of which were in the prone position. The incidents of restraint related to five people over this period.

We examined six care records and found that each patient had a comprehensive risk assessment completed at the time of admission; this included pro-active strategies to manage behaviour. The risk assessment tool used had

been devised by the Danshell Group and was not a specifically recognised tool; however, it was holistic and met the needs of the service. National Institute for Health and Care Excellence (NICE) recommends that services should consider using a formal rating scale such as the aberrant behaviour checklist or the adaptive behaviour scale. We found that in one instance, a patient had been assessed as being at risk of sexually inappropriate behaviour and there was no care management plan in place to manage this behaviour.

We found evidence of blanket restrictions in relation to observations and bedroom door alarms. All patients were subject to staff being alerted if they left their bedrooms. This was regardless of patients risk history or observation levels. This was unnecessarily intrusive of patient's freedoms.

Staff had a good understanding of the rights of informal patients in relation to leaving the hospital. Staff demonstrated good knowledge of the correct procedure in line with the Mental Health Act and Mental Capacity Act.

The provider had a policy in place for the procedure of conducting patient observations. The policy stated that observations of all levels should be clearly evidenced using the observation record form. However, we found that the forms had not been completed for any of the 11 patients. A summary of patient's daily activities was included in the case records and the nursing team was observing patients.

We found evidence that de-escalation was used appropriately prior to any restraint being used. Staff we spoke to demonstrated a good understanding and working knowledge of PBS skills and strategies and least restrictive practice. We reviewed data in relation to restraint and found that de-escalation records were up to date and fully completed.

There was no use of rapid tranquilisation for any patients. This was evidenced in patient care records, prescription charts and staff interviews.

Staff, were trained in safeguarding and understood how to make a safeguarding alert if necessary. Staff we spoke with demonstrated a good understanding of safeguarding issues and knew how to raise a safeguarding concern. Easy read leaflets were available for patients to access and every month topics such as safeguarding were discussed and explained by staff in patient meetings.

There was good medicines management practice in relation to storage, dispensing, and medicines reconciliation. We examined the medicine cupboard and found this to be well arranged and items clearly labelled. Medication was counted on a daily basis and we found this checklist to be correct. All prescription charts were dated and signed. However, it was not clear how often "as required medication" (PRN) was reviewed. The consultant psychiatrist explained that PRN medication was reviewed every two weeks in the multidisciplinary team meetings, but there was no space on the medicine chart to reflect this. The consultant psychiatrist agreed to amend the chart so that this could be recorded. We examined the medication charts and found that medication was prescribed in line with British National Formulary (BNF) guidelines. The consultant psychiatrist demonstrated good practice by explaining and evidencing how attempts were made to prescribe the least medication possible to patients.

A policy for children visiting was in place, which stated that risk assessments should take place prior to the visit and that a designated area should be identified for child visitors. The hospital did not have a specific room for children or family to visit and staff explained that visits usually took place in one of the patient lounges or in the meeting room. Staff said they would supervise these visits if required and complete risk assessments beforehand.

**Track record on safety**

There were three serious incidents requiring investigation reported in the last 12 months. These all related to sexually inappropriate behaviour by patients, either in general or towards staff, such as inappropriate touching. We were informed that following incidents the hospital followed a root cause analysis process. This involved staff receiving both a team de-brief and an individual de-brief. Patients were also offered increased support following incidents. Managers investigated incidents, established what lessons could be learned from them and fed back information to the multidisciplinary staff team to help prevent similar incidents. Staff updated care plans and risk assessments to reflect any change in practice recommended.

**Reporting incidents and learning from when things go wrong**

Good

# Wards for people with learning disabilities or autism

Staff we spoke with were able to identify which incidents required reporting and how they did this in practice. Staff explained that they used an electronic system called Rivo to document all incidents and the nurses or the hospital manager input that information.

Staff confirmed that they were debriefed following an investigation of an incident and received feedback, looking at what worked well and what should change.

## Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

### Assessment of needs and planning of care

Assessments were comprehensive and completed in a timely manner. We saw evidence of good nursing assessments and risk assessments and functional analysis assessments. These were evidence based and regularly updated.

Within the care records, we saw evidence of physical examinations being undertaken. Health problems were being monitored either within the hospital or by the local GP. Five care records showed that patients had health passports and health action plans. One care record did not and this was discussed with the Hospital Manager who agreed to take immediate action. Patients were encouraged and supported with individual health needs such as obesity and smoking.

Four of the six care plans we reviewed were holistic, comprehensive and focussed on patient independence. They showed good evidence of planning for specific goals. They also showed input from the patient and MDT. However two did not demonstrate good practice in the following areas,

- one care record had care plans that were not evidence based or holistic and PBS plans that were not specific or holistic
- one care record had no discharge plan despite this being identified as necessary

All patient records were stored securely in a locked office on the ground floor and staff confirmed that they were easily accessible. Further offices were located near to patient bedrooms on the first floor. At the time of our visit, this door was not locked and patients had easy access to office areas. A staff member working there stated that when leaving the office the door would always be locked in order to protect confidential patient information.

All patients we spoke with confirmed they were aware of the content of their care plans and had been involved in completing them. All patients knew how to access them if necessary, however all patients stated they did not have their own copy due to personal choice.

### Best practice in treatment and care

We found that all prescribing demonstrated good practice and followed, National Institute for Health and Care Excellence, (NICE) guidelines. We found that prescribing was within BNF limits and that no patients were prescribed more than one anti-psychotic medication or any rapid tranquilisation. There was an active strategy in place to keep the prescribing of medication to the minimum possible and promote PBS to manage challenging behaviour. Use of PRN medication (as required) was also minimal. However, improvements were required in relation to reviewing and recording this information.

Patients were offered psychological therapies as recommended by NICE guidelines. Staff undertook functional analysis assessments, which gave relevant detail to support the understanding of patient behaviour and help develop individualised behaviour support plans. Staff described a good working relationship between psychology staff and nursing staff. This was reflected in patient care records.

Patients nutritional and hydration needs were being assessed and met. Patients who were obese were being weighed regularly and had a health promotion plan in place to increase their physical activity and support healthy eating. We reviewed the menus and found that the meals were balanced and of good quality. Patients we spoke with confirmed that they enjoyed the food and had some choice. There was a special menu for patients with dysphagia, (swallowing difficulties). Patients had full access to the kitchen for hot or cold drinks and snacks.

To measure patients' individual progress, staff used various tools such as health of the nation outcome scales for

people with learning disabilities, health equality framework, and the outcome star. These measures were completed, during six-monthly reviews with the patient and discussed in staff meetings.

We found that staff participated in clinical audits such as the medication audit.

**Skilled staff to deliver care**

Staff were from a range of professional disciplines and provided input into the holistic approach to patient care. Staff members included, an occupational therapist (one day a week), an activities coordinator (full time), a psychologist, (three days a week), a psychology assistant, (full time), a consultant psychiatrist, (one day a week), eight learning disability nurses, and 21 support workers. There was no dedicated social worker and support was provided to individuals from their home teams. The speech and language therapist had recently left the hospital and input was temporarily being provided on a sessional basis until the post could be filled.

Nursing staff were appropriately qualified in learning disabilities and had relevant nursing experience. Eight support workers were qualified to qualifications and credit framework (QCF) level three and five were qualified to QCF level two.

All new members of staff received an induction into the service. Staff received regular appraisals and supervision. All clinical staff confirmed they had clinical supervision every two months and management supervision every three months. Staff spoke about management being approachable and that informal supervision occurs regularly from peers, management or within team meetings. Data provided by the hospital showed that 91% of non-medical staff had an appraisal within the last 12 months.

The training schedule showed that staff received training on positive behaviour support (PBS), which is specific to this core service. However, this training was only provided once, to each staff member and was not repeated or refreshed on an ongoing basis. Some staff recognised that this was an important training module and that more formal training was needed. Other staff members spoke about PBS already being embedded through discussion within the MDT's and informal peer support. The hospital provided specialised communication training such as Makaton, Talking Mats, Picture Exchange Communication system, and TEACCH (Treatment and Education of Autistic and Related Communication Handicapped Children).

Extra specialist training was available for staff who would like to apply for it. One nurse told us that the hospital had supported her both financially and with time to upgrade her nursing diploma to a degree level. She had also completed a management course and accessed specialist positive behaviour support training in London. We examined the extra training records and found that other staff members had also completed extra training, which included autism training and personality disorder training.

**Multi-disciplinary and inter-agency team work**

The hospital had weekly multidisciplinary team meetings. Each patient had a full multidisciplinary team review monthly and either weekly or fortnightly reviews of their medication, depending on need. The patients named nurse or the nurse in charge, the occupational therapist, the consultant psychiatrist, the psychologist and the patient attended these meetings. Patients we spoke with described feeling confident to speak up in these meetings and said they did not find them distressing. Nursing staff told us that they spent time before the meeting preparing the patients and supporting them to compile a list of questions if necessary. The activities coordinator explained that if the patient did not want to attend, the nurse would spend time finding out the views of the patient in order to speak on their behalf. We saw evidence of this in the patient files.

The lack of involvement of a speech and language therapist in the multidisciplinary team process affected the treatment of patients. Many patients had communication difficulties and two had dysphagia so the input of a speech and language therapist was important to their safety and progress due to issues with swallowing. The hospital provided a speech and language therapist on a sessional basis only and a special diet was provided. Plans were in place to recruit a new speech and language therapist.

Nursing shift patterns were staggered to take account of the handover process. However, a review of the handover documents for the last month found these to be incomplete. Some dates were missing and some information was difficult to understand, this was due to the day and night shift staff completing their information on the same sheet of paper.

Good

# Wards for people with learning disabilities or autism

Different disciplines within the hospital had good working relationships, which enhanced patient care and treatment. We spoke to the psychologist, psychology assistant, occupational therapist, activities coordinator and nursing staff and found that there is good liaison between staff and that their work is integrated and consistent. This was also reflected in patient care plans and daily notes.

Outside of the organisation, we found strong working relationships between hospital staff and the local GP practice and community voluntary organisations. This was evidenced in patient care records and from speaking to patients and staff. We found that relationships with patient's local area care coordinators and commissioners were varied. Care coordinators and commissioners were regularly invited to care programme approach reviews and were attending a number of these.

**Areas of good practice**

The hospital had made considerable effort to engage patients in activities outside of the hospital setting. Patients were encouraged to participate, as independently as possible, in social and recreational interests in the local community.

Staff from different disciplines worked together as a team for the benefit of patient care. We found good MDT working, which meant that patient care and treatment was holistic and comprehensive.

Staff endeavoured to use de-escalation techniques as much as possible resulting in low incidents of restraint or use of PRN (as required) medication. This allowed the hospital to have a calm atmosphere where patients felt safe and relaxed.

**Adherence to the MHA and the MHA Code of Practice**

Staff were trained in the Mental Health Act and had a good understand of the Code of Practice and guiding principles. Staff we spoke with demonstrated that their knowledge and understanding was good.

The Mental Health Act Monitoring visit in February 2015, found that consent to treatment and capacity assessments in relation to capacity to consent were adhered to and that all documents in relation to consent to treatment were present and correct. Detained patients were read and explained their rights by nursing staff on a monthly basis. We saw easy-read leaflets relating to mental health rights, which were accessible to patients.

There was a central team available to give advice and support in relation to the MHA. Staff we spoke to described a mental health act administrator who was very knowledgeable and helpful and that booklets were available for staff to refer to.

During the inspection process, we examined the MHA audits and found these to be up to date and correctly applied.

Patients had regular access to an independent mental health act advocate who was employed by Voiceability and visited the hospital on a weekly basis. Staff we spoke to were aware of the role and knew how to refer patients to the service.

**Good practice in applying the MCA**

Staff we spoke to demonstrated good understanding of the Mental Capacity Act and the application of this.

The hospital had five patients in total who were subject to Deprivation of Liberty Safeguards, (DoLS) applications.

We found that for those people with impaired capacity, their capacity to consent had been assessed and recorded appropriately. Best interest meetings were held when appropriate. This had been documented in patient care records and was decision specific.

The hospital manager informed us that information regarding DoLS was stored in the office for staff to refer to if necessary.

We also saw evidence of easy read leaflets, which included, "making decisions" and "have your say", which were easily accessible for patients and carers. Staff informed us that they regularly explained information relating to the Mental Capacity Act to patients within patient led forums.

We examined the audits in relation to the Mental Capacity Act, which had been completed in June 2015 and found them to be 99% compliant. In 2014, the compliance rate was 100%

## Are wards for people with learning disabilities or autism caring?

Good

**Kindness, dignity, respect and support**

Good

# Wards for people with learning disabilities or autism

We spoke with five patients at Chesterholme hospital and observed various activities taking place. All five patients told us that the staff were kind and treated them with respect and dignity. The staff knocked on their bedroom doors before they entered. Staff, were always available and offered patients one to one support. The interactions we saw between staff and patients were respectful and supportive. Patients told us that they felt safe, listened to, and that staff responded to incidents.

The families of two patients were happy with the care and treatment being delivered at the hospital. They told us that patients were settled and that the service was meeting their needs. Patients were involved in community activities and encouraged to stay in contact with family and friends.

**The involvement of people in the care they receive**

Patients told us they had been orientated to the hospital and provided with information about their care and treatment. Five patients told us they had sight of, or had signed, or been involved in their care plans. Patients had the opportunity to take part in their MDT meetings, three patients told us they attended and contributed to meetings. We saw evidence in care planning of involvement with patients in MDT and Care Planning Approach, (CPA) meetings. We also saw evidence of attendance and involvement of families in these meetings. Families told us that they were kept up to date about patients' progress at the hospital and felt involved in decisions.

Patients had advocacy support from Voiceability who attended the hospital weekly. Staff had displayed information about the advocacy service on noticeboards around the hospital. The advocate told us that there was a good balance between keeping people safe and encouraging independence.

Weekly involvement meetings took place to discuss issues in relation to the hospital and we saw evidence of "you said, we did" feedback on the notice boards. Meal times had recently been changed at the request of patients during these meetings. Patients attended a regional forum "the people's parliament" and we saw meeting notes to show that Chesterholme patients had attended. Minutes from these meetings were also displayed on the notice boards.

**Are wards for people with learning disabilities or autism responsive to people's needs?**
(for example, to feedback?)

Good

**Access and discharge**

Patients were referred to Chesterholme from all parts of England. The manager and members of the MDT would visit the patient to carry out a pre assessment. Patients were provided with a welcome booklet and pictures to orientate them to the hospital. Patients were seen by the consultant psychiatrist within 24 hours of admission and given a mental health assessment. A physical health assessment is completed and an appointment made with local GP.

The average bed occupancy for the previous six months to this inspection ranged between 56% and 69%. The hospital recently reduced its bed occupancy from 28 beds to16. This is in line with recommendations from the Winterbourne View Report, Transforming Care; Department of Health 2012 that people with learning disabilities should not live in large hospital settings. The impact of this reduction in size was that the hospital was more able to be person centred and patients were able to engage in meaningful activities of their choice.

Patients had been in the hospital for varying lengths of stay with seven patients having stays of five years or less. However, four patients have been with the service for eight years, 13 years, 14 years, and 15 years. All patients had had their care treatment reviews. The hospital manager explained that patients who had been at the hospital for a long time were difficult to discharge due to their complexities and the lack of appropriate and safe provision in the community.

Social workers and commissioners from home teams attended MDT and CPA meetings at least every six months and we saw evidence of this in the patient records. Reports were regularly sent to commissioners to update them on progress of patients. However, the discharge process and discharge rates from the service were often slow, delaying

patients from leaving the hospital. Staff explained they felt frustrated by the lack of progress and that patients were being prevented from moving on due to lack of appropriate placements and problems securing future funding.

Patients were able to access their bedroom on return from home leave and we saw no issues with bed management. The hospital had a separate annex; this was used as a step down service. The annex had three ensuite bedrooms, a kitchen, living room and a separate entrance. One patient was living in the annex at the time of the inspection to prepare for discharge. The patient told us that they use the kitchen to prepare their own meals and had responsibility for keeping the annex clean and tidy, which we found to be the case during the inspection.

The consultant psychiatrist worked with patients to reduce medications and told us that clinical decisions were made to minimise self-harm, aggression and challenging behaviours. Members of the MDT told us that significant complex needs of patients meant that discharge planning could be slow.

The hospital reported that there had been one delayed discharge between 1 February 2015 and 1 August 2015.

**The facilities promote recovery, comfort, dignity and confidentiality**

The wards optimised the recovery, comfort and dignity of patients. The reduced occupancy had allowed some bedrooms to be converted into offices or activity rooms. There was an art and craft room, relaxation room, pamper room and various lounges for patients to relax or watch television.

The patients had single en-suite (sink and toilet) bedrooms with either a shower or bath. They could personalise their bedrooms, and we saw one patient had posters and a calendar of his favourite sports team. Patients had access to lockers to store their possessions. We noted that the signage on the lockers, located at the bottom of a stairwell, would benefit from clearer numbering so that patients could identify their locker more easily.

All patients had access to outdoor space and a well-maintained garden area, with a separate covered smoking area. This area was utilised by one patient as the other patients had been supported to give up smoking. The hospital had rooms where patients could meet their visitors.

Most patients said the food was good and were able to access to hot and cold drinks throughout the day.

Patients could make telephone calls in privacy and had access to mobile phones and electronic tablets dependent upon their individual risks. Some patients used skype to stay in touch with family and we spoke to one patient who skyped home daily.

The activities coordinator led activities during weekdays. At weekends, activities were led by nurses or self-directed. The staff displayed a plan of the activities on the noticeboard in easy read format. Staff had escorted patients to the theatre, ten pin bowling and to outdoor music festivals. Staff encouraged patients to maintain their independence. Patients were supported to attend external activities including horse-riding, swimming, walking, community allotments, local exercise classes, and visits to the local pub. We found that most patients accessed the community daily and took part in voluntary work and/or activities.

Local organisations such as, the Minerva Art College, (specialist learning disability organisation) and Hextal voluntary work, (independent organisation for people with disabilities, and other disadvantages) employed patients as volunteers. Voluntary work included catering, gardening and basic administration duties and volunteers were paid in tokens, which could be used to pay for day trips.

**Meeting the needs of all people who use the service**

The hospital environment had been adapted to meet the needs of the patients. However, we found that a small black number on each door was used to identify bedrooms and that brighter clearer signage would be of benefit to the patients. There was a lift from the bottom floor to the bedroom areas.

Staff had displayed information on noticeboards to inform patients about the hospital. Information about the names of the staff on duty, how to make a complaint, advocacy service and activities were displayed.

Staff had used interpreters for a patient whose first language was not English. We saw evidence of information leaflets in other languages. There was evidence of easy read picture format person centred health plans.

Good

# Wards for people with learning disabilities or autism

There was evidence in care plans that some patients had been losing weight due to improved diet and physical activity. Patients who told us they enjoyed accessing the gym and exercise classes confirmed this.

### Listening to and learning from concerns and complaints

Staff listened to the concerns and complaints of patients. The provider had a complaints procedure in place that staff had displayed on noticeboards. Patients had the opportunity to raise complaints and said they would do this through the manager or other staff members. Patients had access to an advocate to support them with their concerns and told us they would feel comfortable making a complaint.

The hospital manager responded to concerns raised by speaking to the patient and/or family in the first instance to resolve the complaint locally. The operations manager would look at complaints and concerns of a more serious nature. The manager had oversight of all complaints and these were discussed at governance meetings held every two months.

Information provided showed that there had been one formal complaint in the previous 12 months. The complaint was not upheld and related to a patient misusing the internet whilst on the provider network. We were able to speak to the family involved who were happy that the complaint had been dealt with accordingly.

## Are wards for people with learning disabilities or autism well-led?

Good

### Vision and values

Staff knew who the senior managers were and the operations director was present during the first day of our visit and regularly attends meetings based at the hospital.

Staff were aware of the provider's vision and values and we saw that these were displayed on noticeboards around the hospital. Staff stated their personal aims were to improve the services for patients.

### Good governance

Governance systems, such as examining audits, incident reporting, safeguarding and staff training, were in place to monitor the running of the hospital. The hospital manager was accountable to the operations manager who visited the site regularly. A corporate team was based in York and had oversight of the hospital with the manager attending regular monthly meetings to discuss staffing, performance and budget. The hospital had key performance indicators around staff training and budgets, which the hospital manager reviewed on regular basis.

Staff were up to date with mandatory training, which was delivered through the Danshell training academy.

The manager told us that they had authority to manage the hospital and were able to increase staffing levels as required whilst maintaining the overall budget.

A full time administrator worked at the hospital assisting the manager and staff team. Incidents were reported on the electronic system and we saw evidence of learning from these such as changing meal times to accommodate patient's individual needs.

### Leadership, morale and staff engagement

Staff morale was good and staff worked well as a team with support from the hospital manager. We saw staff interacting with the manager in a positive way and that the manager's door was always open for staff to enter and seek support. Staff described the hospital as a good environment to work in with a good caring approach, and a good atmosphere. Staff reported they had regular staff meetings and felt the manager informed them about developments in the organisation. Staff said that they would feel comfortable to raise concerns without fear or victimisation and understood policies around whistleblowing.

Staff had opportunities for leadership development and the provider promoted training. The operations director led leadership training across the services for managers.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that there is a female only lounge available at all times.
- The provider must ensure that all equipment is regularly checked and that there is a system in place to make certain that the senior management team have oversight of this process.

### Action the provider SHOULD take to improve

- The provider should complete all recordings of patient observations as identified in the provider observation policy.
- The provider should risk assess all patients in relation to risks in their bedroom areas and remove door alarms on patients bedrooms for those patients whom this deemed is unnecessary.
- The provider should ensure all care plans and risk management plans are completed and correspond to risks identified in the risk assessments.
- The provider should ensure PRN medication is reviewed and recorded in line with NICE guidance.
- The provider should continue to reduce the ligature risks in a timely manner.
- The provider should increase the provision of speech and language therapy in order to provide holistic care to patients.

The provider should continue to complete and implement discharge plans and work innovatively with commissioners to promote safe patient discharges from the hospital.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The hospital did not comply with gender separation requirements.<br><br>We found Chesterholme Hospital provided facilities to separate patients of the same gender into different areas so their bedrooms were located separately. There were six lounges, five in the main hospital building and one in the annex. However, there was no separate female only lounge, despite the building being refurbished from 2011 onwards.<br><br>This was in breach of Regulation 12 (1) and (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that care and treatment must be provided in a safe way and the provider should ensure that premises are used in a safe way.<br><br>The hospital did not ensure that clinical equipment was regularly checked or replaced when it had expired. We found that a number of items of emergency equipment in the clinic room had expired and had not been checked.<br><br>This was in breach of Regulation 12 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way. |