Oaktree Manor

Quality Report

Heath Road, Tendring
Clacton on Sea, Essex, CO16 0BX
Tel: 01255 871017
Website: www.partnershipsincare.co.uk

Date of inspection visit: 13,14 and 26 February 2018
Date of publication: 11/05/2018

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 Oaktree Manor as good because:

- Managers ensured effective systems were in place to measure the quality of the service. The provider had systems in place to help staff learn lessons from audits, complaints and incidents, through debriefs, team meetings, supervision and bulletins. Managers used these to ensure that sufficient staff were on duty and monitored mandatory training compliance and supervision. The provider operated a system to increase staffing on Fridays to facilitate staff training and administrative tasks without compromising patient care.
- Safe staffing levels had been maintained on all wards. The provider had recruited additional staff since the last inspection and had reduced the use of agency workers from 45% to 30% in the last 12 months. Morale was good and staff teams supported each other effectively.
- Staff compliance with mandatory training compliance was 90%. Staff had access to specialist training in autism and dialectical behavioural therapy. Staff had access to regular supervision.
- Patients were offered debriefs shortly after incidents and periods of seclusion. They were also offered additional debriefs, 48 hours after the event by the psychologist and speech and language therapist.
- Staff completed risk assessments for patients, which were thorough and linked to care plans. Staff completed good quality positive behavioural support plans for all patients, formulated with patient involvement.
- Patients had access to a range of psychological therapies and to a range of activities such as attending a football match, animal care and art therapy.
- Clinical staff completed audits and action was taken as a result. The provider held monthly safeguarding meetings with the local authority and police.
- We observed staff treating patients with kindness, understanding and compassion. Staff understood patients' needs and were motivated to provide high quality care. Carers and patients told us staff were helpful and polite. Patients had access to advocacy, including independent mental health advocates and independent mental capacity advocates, when needed.
- The service had reviewed how they planned and supported patients towards their discharge from hospital. The service still experienced delayed discharges but had made consistent and considerable efforts to work with commissioners to reduce delays. Every patient had a discharge plan and staff supported patients to contact their community teams.

However:

- Managers had not ensured that staff recognised or recorded that prone restraint techniques were utilised on patients to facilitate safe exits for staff from seclusion rooms. The provider had not ensured all patients received four hourly medical reviews during prolonged periods of seclusion.
- The provider completed ligature risks assessments; however, these did not cover all ligature anchor points.
- Not all patients could access outside space at will, particularly when staff were busy.
- Staff's use of physical interventions remained high across the service, although this was decreasing. Staff did not always update patient risk assessments after incidents.
- Staff had not ensured all emergency equipment was safe for use. The emergency oxygen mask on Pine ward was out of date and had deflated.
- Staff had not documented best interest decisions for two patients who lacked capacity.
- There was a lack of patient involvement documented in some risk assessments.
- The average length of stay for patients was 918 days across the service. This is higher than the national average of 554 days. The average length of stay on Yellowwood ward was 1150 days.
- Patients stated that food was sometimes 'greasy' and choices, including vegetarian options, were limited.
- Multi-faith rooms on the wards did not contain all the required literature or equipment.

Summary of findings

Contents

Good

Oaktree Manor

Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Oaktree Manor

The provider for this location is Partnerships in Care (Oaktree) Limited and the corporate provider is Arcadia. As of 1 December 2016, there had been changes to the corporate provider as two organisations, Partnerships in Care and Priory Healthcare Limited, had merged.

Oaktree Manor has six low secure wards with 47 beds and offers inpatient care and treatment for people with a diagnosed learning disability, autism and mental health needs. Oaktree Manor has been registered with CQC since 13 December 2010. This location is registered to provide the following regulated activities: diagnostic and screening procedures; assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

The low secure wards at Oaktree Manor admit patients with a primary diagnosis of learning disabilities:

- Cherry and Yellowwood wards – for women, with eight beds in Cherry ward and seven beds in Yellowwood ward
- Maple and Pine wards – for men, with eight beds in each ward
- Rowan and Redwood forensic wards – for men, with eight beds in each ward

There have been five inspections carried out at Oaktree Manor. The most recent being on 10-11 January 2017. When we last inspected, we rated Oaktree Manor as 'requires improvement' overall. The safe and responsive domains were rated as requires improvement; the effective, caring and well led domains were rated as good.

We told the provider they must take the following actions and issued a requirement notice for a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, Regulation 9, person centred care and Regulation 12, safe care and treatment.

- The provider must ensure that staff reviews of patients in seclusion take place as per their policy and the Mental Health Act 1983 code of practice.
- The provider must review their processes for planning and supporting patients towards their discharge from hospital.

The provider sent us a plan following the inspection detailing the actions they would take to address this. Following this inspection, we found further issues with the monitoring of patients in seclusion. However, significant progress had been made with planning and supporting patients towards their discharge.

We also said the provider should take certain actions:

- The provider should review their recruitment and retention policies to reduce the number of staff vacancies.
- The provider should ensure review their process for identifying, managing and removing ligature risks.
- The provider should ensure that patients are effectively involved in debriefs following restraints.
- The provider should ensure that patient care records systems are consistent and that staff have easy access.
- The provider should ensure that electronic patient care records adequately reflect patients' views.
- The provider should review their systems for gaining and acting on feedback from patients regarding food.
- The provider should review their communication systems with carers to ensure they receive regular updates on patients care as relevant.
- The provider should review their systems in place to engage with staff at the hospital.
- The provider should ensure that the hospital comply with reporting requirements for the Workforce Race Equality Standard.

Since February 2017, there have been three Care Quality Commission visits by mental health act reviewers. On Redwood and Rowan wards, concerns were raised about patients having to tell staff who they were calling before using the telephone and recording outcomes of patient leave. The provider had plans in place to address these issues.

Mrs Beatrice Nyamande is registered with the Care Quality Commission as the registered manager and as the controlled drugs accountable officer.

Summary of this inspection

Our inspection team

The team that inspected the service comprised four CQC inspectors, two inspection managers, two specialist advisors and an expert by experience.

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.

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 10 patients who were using the service;
- spoke with four carers of patients at the service;
- spoke with the registered manager and managers for each of the wards;
- spoke with 25 other staff members; including doctors, nurses, healthcare assistants, occupational therapist, psychologist, social worker, speech and language therapist, Mental Health Act administrator and housekeepers;
- received feedback about the service from NHS England;
- spoke with an independent advocate;
- attended and observed two hand-over meetings and two multi-disciplinary meetings;
- looked at 13 care and treatment records of patients;
- carried out a specific check of the medication management on all six wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to 10 patients who used the service. They spoke positively about most staff. They told us they were kind and helpful and involved them in the care they received. However, five patients said they did not feel safe. Four of these patients said this was because other patients attacked or bullied them. Five service users at the patients' forum said that there were not enough trips out due to a lack of drivers and that some staff shouted and were not friendly.

We spoke with four carers of patients who lived at the service. They all spoke positively about the staff and the quality of care their relative received. They all said they were confident their relative was safe at the service and the hospital tried to involve them, for example in meetings and facilitating home leave. However, one carer said staff did not always tell them about incidents that had happened until they were told by their relative.

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:

- Managers had not ensured that staff recognised or recorded that prone restraint techniques were utilised on patients to facilitate safe exits for staff from seclusion rooms.
- The provider had not ensured all patients received four hourly medical reviews during prolonged periods of seclusion.
- Although levels of physical restraint had reduced in the last six months of 2017, they remained high across the service, particularly on Pine, Yellowwood and Maple wards.
- The provider completed ligature risks assessments; however these did not cover all ligatures on the wards.
- Not all patients could access outside space at will, particularly when staff were busy.
- Staff did not always update patient risk assessments after incidents.
- Staff had not ensured all emergency equipment was safe for use. The emergency oxygen mask on Pine ward was out of date and had deflated.

However:

- The use of physical interventions had decreased substantially over the past eight months.
- Staff compliance with mandatory training compliance was 90%.
- The provider ensured safe staffing levels had been maintained on all wards.
- Staff completed risk assessments for patients, which were thorough and linked to care plans.
- The provider's seclusion rooms complied with Mental Health Act Code of Practice 2015.
- Staff learned from incidents through team meetings, handovers and supervision.
- Patients were offered debriefs shortly after incidents and periods of seclusion. They were also offered additional debriefs, 48 hours after the event by the psychologist and speech and language therapist.

Summary of this inspection

Are services effective?

Good

We rated effective as **good** because:

- Staff completed good quality positive behavioural support plans for all patients and supported them to write their own plans where possible.
- Medical staff prescribed medication in accordance with national institute of health and care excellence guidelines and did not prescribe antipsychotic medication at high doses.
- Clinical staff completed audits and action was taken as a result.
- Patients had access to independent mental health advocates and independent mental capacity advocates when needed.
- Staff had access to specialist training in autism and dialectical behavioural therapy. Staff had access to regular supervision.
- The provider held monthly safeguarding meetings with the local authority and police.

However:

- Staff had not documented best interest decisions for two patients who lacked capacity.

Are services caring?

Good

We rated caring as **good** because:

- The provider had involved patients and captured their views in positive behavioural support plans and discharge plans.
- We observed staff treating patients with kindness, understanding and compassion.
- Staff understood patients' needs and were motivated to provide high quality care.
- Carers told us staff were helpful and polite.
- Patients had access to advocacy.

However:

- There was a lack of patient involvement documented in some risk assessments.

Are services responsive?

Good

We rated responsive as **good** because:

- The service had reviewed how they planned and supported patients towards their discharge from hospital. The service still experienced delayed discharges but had made consistent and considerable efforts to work with commissioners to reduce delays.
- Every patient had a discharge plan and staff supported patients to contact their community teams.

Summary of this inspection

- Staff ensured patients were kept informed following making complaints. Information was available in easy read format and explained by staff.
- Patients had access to a range of activities such as cooking, walking, swimming, shopping, attending a football match, animal care and art therapy.
- Complaints were dealt with quickly and lessons learned were fed back to staff.

However:

- The average length of stay was 918 days across the service. The average length of stay on Yellowwood ward was 1150 days. This is higher than the national average of 554 days.
- Patients stated that food was sometimes 'greasy' and choice, including vegetarian options, was limited.
- Multi-faith rooms on the wards did not contain all the required literature or equipment.

Are services well-led?

Good

We rated well-led as **good** because:

- Managers had ensured effective systems were in place to measure the quality of the service. Managers used these to ensure that sufficient staff were on duty and monitor mandatory training compliance, supervisions and appraisals.
- The provider operated a system to increase staffing on Fridays to facilitate staff training and administrative tasks without compromising patient care.
- The provider had recruited additional staff since the last inspection and had reduced the use of agency workers from 45% to 30% in the last 12 months.
- The provider conducted audits and took action to address issues arising from them.
- The provider had systems in place to help staff learn lessons from audits, complaints and incidents, through debriefs, team meetings and bulletins.
- Staff were aware of who senior managers were said they were visible on the wards.
- Morale was good and staff teams supported each other effectively.
- The provider was a member of the quality network for forensic mental health services, meeting 91% of the standards.

However:

- The provider had not ensured that staff had recorded incidents of prone restraint during episodes of seclusion.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- At the time of our inspection all patients were detained under the Mental Health Act. This included some patients on Part III of the Act who were detained because they had committed a criminal offence.
- The provider had systems in place to ensure that they complied with Act and that the correct documentation had been completed for detained patients. Staff completed Mental Health Act paperwork correctly.
- The Mental Health Act administrator conducted regular audits of Mental Health Act paperwork to ensure everything was correct and in order. We saw that learning had taken place from a previous error and that new systems had proved effective.
- The provider recorded that they read patients their rights under the Act regularly.
- As of December 2017, 80% of staff had up to date training in relation to the Mental Health Act and the Mental Health Act code of practice. Staff had a good working knowledge and understanding of the Act and its application.
- We looked at 24 medication charts. Correct consent to treatment forms were in place and attached for staff reference to ensure medication was administered under the appropriate legal authority. Staff knew how to contact the Mental Health Act administrator when they needed advice and support.
- Patients had access to independent Mental Health advocacy services and staff knew how to access this support for patients. Staff ensured contact details were displayed on all wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

- As of December 2017, 78% of staff had received training in the Mental Capacity Act and 90% of staff had received training in Deprivation of Liberty Safeguards. Staff had a good, basic understanding of the Act. Registered staff had a more in-depth knowledge of the Act and completed mental capacity assessments and best interest decisions where appropriate. However, staff had not documented best interest decisions for two patients who lacked capacity.
- There were no Deprivation of Liberty Safeguards applications made in the last six months.
- The provider had an up to date policy for the Mental Capacity Act and Deprivation of Liberty Safeguards for staff reference.
- The Mental Health Act administrator supported staff and gave advice when needed. Staff were aware of how to access this support.
- Patients were supported to make their own decisions whenever possible. Mental capacity assessments had been completed for some patients who had been assessed as lacking capacity to make specific decisions. However, in two records where the patient had been assessed as lacking capacity, no best interest decision had been documented.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	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

- Patients were accommodated in single sex wards. Therefore, the provider was compliant with the Department of Health's guidance on the provision of single sex accommodation.
- The layout on the wards did not allow staff to observe patients in all areas and there were some blind spots. These risks were managed by mirrors and by staff patrolling areas to ensure patients could be observed clearly.
- There was no nursing office on Pine or Rowan wards. Nursing offices on Maple and Redwood wards did not allow staff to view all areas of the ward. Staff maintained observations throughout these wards to keep patients safe.
- Staff had difficulty locating the ligature risk assessments on Redwood and Rowan wards. A ligature risk is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Some ligature risks had not been identified on the ligature risk assessment, such as radiator covers and toilet seats. We were not assured that staff were aware of all ligatures risks or had information for how these were to be safely managed. Staff on Maple and Pine wards had highlighted ligature risks on laminated sheets. The provider had a rolling programme to reduce ligature risks, particularly in en-suite bathrooms, which was not yet completed.
- Clinic rooms were fully equipped, clean, tidy and well organized. There were clinic rooms on each of the six wards. Medication was mostly administered from general stock, although there a small number of medications for named patients. These were labelled separately. Medication was audited weekly by the external pharmacist.
- The clinic rooms on Pine ward, Rowan ward and Yellowwood ward contained emergency equipment, including a defibrillator and resuscitation equipment. Maple ward, Redwood ward and Cherry ward used the emergency equipment in their adjoining ward when needed. Emergency equipment on Rowan and Yellowwood wards had been checked regularly, was calibrated and was in date. However, on Pine ward, the oxygen face mask had expired three months prior to our inspection and was not adequately inflated. It was therefore, not ready for use in an emergency. Blood glucose test strips were also out of date. We raised these issues with the provider and they were rectified during the inspection.
- The provider had three seclusion rooms, on Pine ward (also for patients on Maple ward), Rowan ward (also for patients on Redwood ward), and Yellowwood ward (also for patients on Cherry ward). This meant that some patients had to go through another ward to reach the seclusion room. Seclusion rooms complied with the guidance set down by the Mental Health Act Code of Practice (2015). There were no identified ligature points, observation was clear, blind spots were minimal and the provider managed staff observation with mirrors and

closed circuit television. Staff viewed this from the adjoining observation room. The temperature in the seclusion room on Pine ward was extremely cold. However, staff had easy access to temperature controls and the ward manager told us during periods of seclusion the temperature was maintained at 22 degrees centigrade.

- Wards were clean, tidy and well maintained. Furnishings were generally of good quality and in good condition. However, there was a strong smell of urine on Maple ward. On Redwood ward, a patient's bathroom had been boarded up due to the bathroom being damaged and presenting a high level of risk. This meant that the patient had to use an empty bedroom to access toilet facilities. We raised this with the provider who facilitated an immediate change of room for the patient.
- Staff had access to emergency alarms to summon help when needed.
- The provider deployed a nurse as an infection control lead to support staff to follow policy in relation to hand washing, food hygiene and general infection control issues such as ensuring mattresses were cleaned. Hand washing gels were available throughout the hospital.

Safe staffing

- The provider had calculated how many staff were required to provide safe staffing to patients. The nursing establishment across the hospital was 31 nurses and 99 healthcare workers. Vacancy rates for nurses were 24% and 22% for support workers over a 12 month period from December 2016 to December 2017. However, the provider had recently increased the establishment for support workers, which meant that the vacancy rate for healthcare workers at the time of the inspection was 36% with 36 vacancies. There were nine nursing vacancies, a vacancy rate of 29%. The provider had an ongoing recruitment process in place to attract new staff to the service.
- The provider used both bank staff and agency staff to fill shifts. The provider used four agencies to book staff to cover sickness and unfilled posts. The provider stated that 30% of shifts were covered by agency workers, which had decreased from 45% 12 months previously. These were mostly block booked in advance with workers familiar with the service and specific wards wherever possible. Between 1 September and 30 November 2017, 798 shifts were covered by agency staff in relation to sickness, absence or vacancies. During this period, there were 252 shifts which could not be covered by bank or agency staff. The provider told us these shifts were covered by existing staff, including ward managers, working additional hours.
- The provider assessed and adjusted staffing levels according to the number of individual observation required. Ward managers were able to adjust staffing levels when needed. Staffing levels were reviewed daily at the early morning meeting, including any increases in observations for patients. There were enough staff to complete physical interventions safely with patients.
- Most staff stated that staffing levels were safe. Staff told us it was rare for activities or leave to be cancelled or for patients not to receive individual time from their named nurse because of staff shortages. Staff told us that short staffing was rare but could lead to some activities, escorted leave or staff breaks being postponed. Two staff also raised issues about whether staffing levels met the needs of the patients.
- The provider did not collect sickness and absence rates for this service by wards. Data from the provider stated that the overall sickness rate for the hospital was low at 2% between 1 January and 31 December 2017.
- The provider had two full time consultants and a full time associate specialist who provided 24 hour medical cover. Doctors were allocated to specific wards but covered each other's work when needed. The provider operated an on call duty rota to ensure medical input was always available. Out of hours, there was no medical cover on site. However, doctors were able to attend the ward when needed within one hour.
- Data from the provider stated that mandatory training compliance stood at 90%, which was in line with provider's target. In 13 of the 24 mandatory courses, compliance was 90% or higher. However, four courses had compliance rates of under 80%. These were 60% for basic life support with defibrillator, 75% for immediate life support, 75% for fire safety and 78% for mental health act training.

Assessing and managing risk to patients and staff

- The provider reported 121 episodes of seclusion across the service between 1 June and 30 November 2017. This was highest on Yellowwood ward with 57 incidents and Pine ward with 38 incidents. On Redwood ward there were no incidents of seclusion over the same period. Information from the provider received ahead of the

inspection stated that for the same period, there had been five instances of long term segregation, three on Yellowwood ward, one on Cherry ward and one on Rowan ward.

- Staff use of physical interventions was high across the service. This had declined over the previous six months by 25% (although was higher than for the first six months of 2016). The provider reported 657 episodes of restraint across the service between 1 June and 30 November 2017. On Pine ward there were 289 restraints in relation to five patients; on Yellowwood, there were 170 restraints in relation to six patients; and on Maple ward there were 124 restraints relating to seven patients.
- Staff stated that they used de-escalation techniques and strategies in positive behavioural support plans to ensure that restraint was used only as a last resort. The provider told us that prone restraint no longer took place and was no longer included in their physical interventions training. This included occasions when rapid tranquillisation was administered, which was conducted in the supine (face up) position. The provider stated that between 1July and 31 December 2017, there were four episodes of prone restraint, two on Yellowwood ward and two on Pine ward. A prone restraint occurs when someone is placed face down on a surface and is physically prevented from moving out of this position. There are concerns that face down, or prone, restraint can result in dangerous compression of the chest and airways and put the person being restrained at risk.
- The provider's policy on restraint did not identify specific restraint techniques for staff to use, including prone restraint. However, five nursing staff and two managers we spoke with told us although prone restraints did not take place when placing a patient in seclusion, the prone position was consistently used, for a few seconds, as an exit technique.
- We were not assured that staff were aware they were using prone techniques to restrain patients during exits from the seclusion room and were not, therefore, recording it. We looked at closed circuit television footage in relation to four episodes of seclusion. All showed that staff used prone techniques to exit the seclusion room. In three of the four incidents we looked at, time in the prone position was approximately three to four seconds. However, in one incident, the patient was held in the prone position for one minute and 12 seconds. Prone techniques we observed were applied safely, and in line with the provider's previous training; however, they were not being recorded as prone restraints on incident forms or in seclusion records. We raised this with the provider during the inspection, who issued an instruction to staff. We saw that records for an episode of seclusion after this communication did record that prone restraint was used to exit the seclusion room.
- We were not assured that all patients were receiving four hourly medical reviews during prolonged periods of seclusion. During our last inspection we observed that some medical reviews had not been completed within an hour of seclusion starting. We reviewed 22 seclusion records. Seclusion records had recorded medical and nursing reviews and nursing observations. In each case the doctor completed a medical review within an hour of the seclusion starting. There were three instances where the seclusion exceeded four hours. In two of these there were medical reviews at four hourly intervals in line with the Mental Health Act code of practice. However, in one of the records, it was not documented that a patient had been seen by a doctor during seclusion for a period in excess of 15 hours. The patient had two hourly nursing reviews during this period. The provider's seclusion audit for July to December 2017 also identified that four hourly medical reviews were not recorded for some patients, although this did not specify how many.
- The provider reported 97 incidents of rapid tranquillisation between 1 July and 31 December 2017. There were 50 incidents on Yellowwood and Cherry wards and 46 on Maple and Pine wards. Four of these were completed with the patient held in the prone position. In the remaining 93 incidents, intramuscular medication was administered in the supine position where the patient was rolled onto their side. Staff had recorded these incidents of prone restraint on the electronic incident recording system.
- We looked at 13 patient records. Staff had completed risk assessments for all patients, which included information about the patient's history in relation to risks and their current presentation. Risk assessments were thorough and linked to care plans to show how risks should be managed. However, staff did not consistently update risk assessments after incidents and in three records, risk assessments had not been updated since admission.

Good

Wards for people with learning disabilities or autism

- The provider had policies and processes in place in relation to observations. This included protocols that staff should not complete more than two hours of observations without a break and guidelines about positive engagement with patients during observations. Records we looked at showed the provider complied with this policy.
- Access to the garden areas was variable. Patients with section 17 leave arrangements had free access to outside space. However, the provider advised that each patient had a care plan to access the secure garden areas. We saw the ligature risk assessments stated that patients were escorted, supervised or monitored to access the secure gardens at all times. We were, therefore, concerned that not all patients could access outside space at will, particularly when staff were busy.
- The provider did not offer internet access on the wards. However, internet access was provided under staff supervision at the Oaktree Centre.
- Staff received mandatory safeguarding training. Compliance rates across the service were 90% for safeguarding vulnerable adults and 92% for safeguarding children. Staff were aware of how to make a safeguarding referral and knew where to go to seek further advice when necessary.
- The provider worked with a local pharmacy to ensure appropriate management and dispensing of medication to patients. The pharmacist conducted weekly audits to ensure medicines were being stored and dispensed correctly.
- Children did not visit the wards at this service. The provider had meeting rooms available off the wards where visits could be facilitated safely following appropriate risk assessments.

Track record on safety

- The provider had identified 18 serious incidents between 1 December 2016 and 30 November 2017. The most frequent types of incident were patient on patient assault, incidents of self-harm and alleged assaults by staff on patients. Pine ward had the most with seven incidents. Maple had five incidents and Yellowwood had four. These incidents had all been investigated appropriately.

Reporting incidents and learning from when things go wrong

- All staff reported incidents on the electronic incident reporting system.
- Staff learned lessons from incidents through monthly lessons learned bulletins, team meetings, handovers, early morning review meetings, supervision and debriefs. Learning included feedback from investigations and looking at incidents from other hospitals within the Priory group.
- Staff were offered support and debriefs after incidents. Incidents were discussed at handovers and early morning review meetings and through supervision.
- Patients were offered debriefs after incidents and periods of seclusion. They were also offered additional debriefs 48 hours after the event by the psychologist and speech and language therapist.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We looked at 13 patient records. These were electronic, held securely and available to staff when needed by logging in and providing passwords. Any paper copies of care plans, my shared pathway and positive behavioural support plans were locked in ward offices.
- Care records contained detailed information about patients and included physical health examinations and monitoring of physical health issues and conditions.
- Care records were generally up to date although we found one record where care notes had not been updated for over two weeks. Care plans were holistic and detailed and were personalised to each patient and focused toward recovery and discharge. Involvement by the patient and their carer was not documented in care plans, but was evidenced in positive behavioural support plans and my shared pathway.

Best practice in treatment and care

- We saw evidence the provider followed national institute of health and care excellence guidance when

prescribing medication. We looked at 24 medication charts. Staff completed consent to treatment forms correctly and held these with patient medication charts for staff reference. Psychotropic medication was not prescribed at high doses in the records we examined. The provider completed monthly audits, in line with national institute for health and clinical care excellence guidelines for prescribing antipsychotics and guidance on the use of psychotropic medicines in people with learning disabilities whose behaviour challenges (2017).

- We saw evidence that the provider monitored patients' physical health and provided access to physical health interventions, such as dentists, when appropriate. Modified early warning scores (MEWS) were completed and available for all patients. The service had employed a physical health nurse to support patients with physical health conditions and improve awareness of health promotion issues. The practice nurse facilitated health promotion groups to encourage patients to manage their own health. Recent groups facilitated included the well women's and men's health promotion groups.
- Patients had access to a range of psychological therapies recommended by the national institute for health and care excellence. These included dialectical behavioural therapy, cognitive behavioural therapy and individual work with patients in relation to their offences. Some patients were supported in this by the speech and language therapist where appropriate. The provider monitored patient outcomes to assess the effectiveness of treatment.
- The psychologist completed functional assessments of patients, and worked with patients and multidisciplinary team members, including nursing staff, to produce positive behavioural support plans. These focused on positive and proactive strategies before detailing reactive strategies. All patients had positive behavioural support plans and the service promoted this approach across the hospital. Staff told us that this approach was part of their strategy for reducing restrictive practice.
- The speech and language therapist assessed the communication needs of patients on admission, offered a range of therapeutic interventions and completed communication passports and care plans. They also undertook dysphagia assessments and formulated management plans for patients.
- The hospital has software installed in the ward computers and an operating licence to produce accessible and easy read literature for the patients. Staff received training from the speech and language therapist to operate the software.
- Clinical staff completed audits, for example in relation to medication, infection control, ligatures and seclusion practices and documentation.

Skilled staff to deliver care

- The provider employed psychologists, psychiatrists, nurses, healthcare workers, occupational therapists, a speech and language therapist and a social worker. They also had access to an independent advocate and pharmacist. Staff held professional qualifications, where relevant, and were experienced in working with this client group.
- Staff received a two week induction prior to working on the wards. This included training in the Mental Health Act, Mental Capacity Act, physical interventions, safeguarding and the safe handling of medicines. Training was a mixture of face to face training sessions and electronic learning.
- Data from the provider showed staff received supervision every four to six weeks. Pine ward had the lowest staff compliance with 92% of staff receiving supervision, slightly below the provider's target of 95%. Rowan ward was the highest with 97% compliance. All other wards met or exceeded the 95% target. Staff told us they received monthly supervision. We looked at supervision records over the previous six months for eight people on Cherry and Yellowwood wards. Staff received praise for their work and managers supported them when they raised issues about their wellbeing and workload. Staff discussed training issues and managers shared lessons learnt from incidents across the hospital. However, it was unclear from three records when supervisions had taken place as dates had been crossed out and replaced.
- The provider submitted data that showed 90% of staff had received an appraisal in the previous 12 months. Staff confirmed that they received appraisals every year.
- Staff attended monthly team meetings. Ward staff were split into two teams to ensure that all staff could attend. We looked at team meeting minutes for November and December 2017 and January 2018. Managers reviewed seclusion and long term segregation, incidents (including lessons learned), safeguarding concerns,

section 17 leave, patient engagement, security and staffing numbers. There was also an opportunity for staff to raise issues and receive policy and legislation updates. Minutes showed that comprehensive discussions had taken place.

- Staff received specialist training, for example in positive behavioural support, autism and dialectical behaviour therapy. The provider supported four healthcare workers to complete nursing training.

Multidisciplinary and inter-agency team work

- The provider held regular multidisciplinary meetings. We observed an early morning meeting, attended by senior managers, ward managers and other members of the multidisciplinary team. These meetings were held daily and covered issues that had arisen from the previous day, such as medication, seclusion or safeguarding. The meeting focused on patient care. There were also discussions about new referrals and arrangements to assess patients, staffing and discharges.
- Staff held weekly ward rounds and each patient was seen monthly. The multidisciplinary team, including ward staff, external commissioners and care co-ordinators, where appropriate, attended ward rounds. We observed a ward round and found it was comprehensive and included the views of the patient. Staff facilitated care programme approach meetings for patients and took part in regular care and treatment reviews.
- The provider held twice-daily handovers between shifts where information about incidents and patients was passed to the oncoming shift. Staff told us these were led by the registered nurses and were informative.
- The provider had good relationships with external teams, including NHS England, commissioners, primary care services and the local authority safeguarding team. They held monthly safeguarding meetings to review safeguarding investigations with the police and the local authority.

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

- At the time of our inspection, all patients were detained under the Mental Health Act. This included some patients on Part three of the Act who were detained because they had committed a criminal offence.
- The provider had systems in place to ensure they complied with Act and the correct documentation had been completed for detained patients.
- The provider had recorded they informed patients their rights under the Act regularly.
- As of December 2017, 80% of staff had up to date training in relation to the Mental Health Act and the Mental Health Act code of practice. Staff had a good working knowledge and understanding of the Act and its application.
- We looked at 24 medication charts. Correct consent to treatment forms T2 and T3 were in place and attached for staff reference to ensure medication was administered under the appropriate legal authority. A form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. A form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.
- Staff knew how to contact the Mental Health Act administrator when they needed advice and support.
- Staff completed Mental Health Act paperwork correctly.
- The Mental Health Act administrator conducted regular audits of Mental Health Act paperwork to ensure everything was correct and in order. We saw that learning had taken place from a previous error and that new systems had proved effective.
- Patients had access to independent mental health advocacy services and staff knew how to access this support for patients. Staff ensured contact details were displayed on all wards.

Good practice in applying the Mental Capacity Act

- As of December 2017, 78% of staff had received training in the Mental Capacity Act and 90% of staff had received training in Deprivation of Liberty Safeguards. Staff had a good, basic understanding of the Act. Registered staff had a more in-depth knowledge of the Act and completed mental capacity assessments and best interest decisions where appropriate.

Good

Wards for people with learning disabilities or autism

- There were no Deprivation of Liberty Safeguards applications made between 1 June and 30 November 2017.
- The provider had an up to date policy for the Mental Capacity Act and Deprivation of Liberty Safeguards for staff reference. The Mental Health Act administrator supported staff and gave advice when needed. Staff were aware of how to access this support.
- Patients were supported to make their own decisions whenever possible. Mental capacity assessments had been completed for some patients. However, in two records where the patient had been assessed as lacking capacity, no best interest decision had been documented.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- During the inspection we saw staff treating patients in a kind, respectful and caring manner.
- Patients told us staff were friendly and helpful and treated them with respect. We spoke with 10 patients. Most said that staff were positive, respectful and relaxed. For example, they would always knock and wait an answer before entering their room. However, one patient said that staff could talk to them more when they were getting upset, and patients said that some staff shouted and were not as respectful as they should be.
- Carers said that staff were helpful, kind and friendly and knew about their relative's needs.
- Staff we spoke with showed an understanding of their patients and their needs. They were committed to providing high quality care to patients.
- The hospital used dignity champions to raise awareness among staff about discrimination and to work directly with patients. The hospital used dignity champions to raise awareness among staff about discrimination and to work directly with patients.

The involvement of people in the care they receive

- Staff provided patients with information about the hospital on admission.
- Staff completed care plans and risk assessments for patients. Sections detailing patients and carer's views were left blank in five of the risk assessments we reviewed. However, the provider advised that patients were involved in HCR-20 assessments and their consent to completion of this assessment was sought. The HCR-20 is a comprehensive set of professional guidelines for the management of violence risk.
- Patients' care plans did not describe how they had been involved in care planning. Staff recorded that patients had been offered a copy of their care plan and that it had been discussed with them. Patients confirmed they had copies of their care plans and told us they regularly reviewed and updated these with their named nurse. Patients also had copies of "My shared pathway" and positive behavioural support plans and were involved in formulating these plans.
- Patients had access to independent advocacy. The advocate worked with patients after incidents and safeguarding referrals and supported them to make complaints where appropriate. They also supported a patients' forum where patients discussed issues that affected them and gave feedback to the service. We saw examples of the provider responding to patient concerns, for example in relation to food where the provider arranged for tasting menus for patients to test and comment on. Patients also told us they received feedback when they raised issues.
- Carers said they felt positive about the communication they had with the hospital and were involved in review meetings such as care programme approach meetings. One carer told us they received a call each week to update them on their relative's progress.
- We did not see any examples of advance decisions in place for patients in the records we reviewed.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The provider's data showed average bed occupancy between 1 June and 30 November 2017 was 94%.

During this period, Yellowwood, Cherry and Pine wards had 100% occupancy. Rowan, Redwood and Maple wards had an occupancy rate of 88%. Oaktree Manor took referrals nationally and had a high percentage of out of area placements. Due to the high level of occupancy, a waiting list was in operation. Therefore, beds are not routinely available to patients living in the catchment area.

- Staff facilitated periods of home leave for patients. Access to a bed was always available on return from leave. Patients were not routinely moved between wards during periods of care. Managers told us this would only occur for clinical and therapeutic reasons.
- At the time of our inspection, the average length of stay was 918 days. This was highest on Yellowwood ward at 1150 days and lowest on Maple ward at 689 days.
- The service had reviewed their processes for planning and supporting patients towards their discharge from hospital and worked with commissioners to reduce delays. At the time of our inspection there were 13 delayed discharges across the service. The provider defined this as patients who they had assessed as fit to discharge but had not yet been discharged. The service discharged 10 patients in the 12 months prior to the inspection, all of which went to less secure placements.
- The provider held monthly meetings to discuss delayed discharges and invited NHS England case managers to attend. Care and treatment reviews had taken place for the majority of patients and plans had been made for discharge where appropriate. Reasons for delays to discharges were documented. These were clinical need, assessments not being completed, funding not being applied for, funding not being agreed, placements not being identified by commissioners and placements failing because of financial or staffing issues. We saw evidence the provider had consistently raised these issues with commissioners and external care co-ordinators and tried to move the process forward. The registered manager was the point of contact for all delayed discharges and made attempts to set up professionals meetings to seek solutions.
- Staff produced discharge plans for patients. We looked at 11 plans. There was clear evidence that staff had produced these plans with patients. Many had been written by patients with support from staff. They outlined the patients' hopes about where they would live and what support they would need. All had review dates dependent on the patients' readiness for discharge and whether placements and funding had been identified and confirmed. Patients confirmed their involvement in these plans and told us they updated them regularly with staff. Patients told us they got frustrated by the lack of communication from their commissioners and delays in being discharged. Staff supported patients to contact their commissioners.

The facilities promote recovery, comfort, dignity & confidentiality

- The service had a number of rooms on the wards for 1:1 sessions, individual and group activities and therapy work. There were also meeting rooms outside the ward, in the main office building and in the adjacent Oaktree Centre. There were quiet areas on and off the wards where patients met visitors.
- The clinic rooms contained all necessary equipment for safe care and treatment.
- Patients could personalise their bedrooms if they wished. We saw examples where patients put up pictures and displayed personal belongings in their rooms.
- The provider had a rolling programme of works on all the wards. We saw that en-suite bathrooms had been updated and managers told us that they had a further seven to complete. However, one patient was unable to access the en-suite bathroom in his bedroom and had to use the bathroom in an empty bedroom. We raised this with the provider who immediately moved the patient to a more suitable room.
- Patients had access to outside garden areas under supervision. Patients could also access the Oaktree Centre and the local community with staff supervision. There were also horticultural opportunities at the Oaktree Centre. Some patients could go for a walk in the grounds unescorted, subject to risk assessment.
- Patients could make private phone calls on their mobile phones. These were locked away by staff but provided on request. Patients could also use the ward phone and there were payphones available. However, two patients said that they felt these conversations were not private and that staff were listening.
- Patients said the food overall was good. There was a discussion about food at the patients' forum. Patients said they were able to sample new recipes and make comments and there were a number of healthy options and some choice. However, they also said that

sometimes the food was greasy, the choice was sometimes limited and that there was not always enough. The provider was still providing the main meal at lunchtime. The provider was able to meet the dietary needs of patients from different cultures or who had specific dietary needs or preferences. There was one vegetarian option provided each day, meaning that choice for vegetarians was limited. Other diets such as vegan, halal, kosher and gluten free options were available on request from the catering staff but were not integrated into menu plans. The provider offered a health promotion course which promoted healthy eating.

- Patients told us they were able to have snacks but there were often set times for these and this could be more flexible. Patients accessed the kitchen to make a drink but had to request staff to do so. One carer said their relative liked the food, another that their relative did not. Two carers told us that their relative had put on a lot of weight since admission.
- Patients had access to activities such as cooking, walking, swimming, shopping, attending a football match, animal care and art therapy. Patients told us they had choice but this was sometimes limited. The provider facilitated some trips out. Patients said they would like to do this more often but this was not possible due to the lack of drivers. The provider employed occupational therapy staff to engage patients in therapeutic activities.

Meeting the needs of all people who use the service

- Wards were on ground level and were accessible for patients with mobility difficulties.
- Wards did not display information leaflets in languages other than English but staff accessed these on request. The provider also had access to interpreters when needed, to speak to patients or inform them of their rights under the Mental Health Act. Patients had access to easy read information and the speech and language therapist worked with patients and staff on the wards to enable patients to understand and communicate their wishes.
- The provider displayed information about treatments, advocacy and complaints in accessible formats across all the wards.
- There were multi-faith rooms on all the wards and at the Oaktree Centre. The multi-faith rooms on the wards were not well furnished. Staff told us they had arranged visits to churches and mosques for patients. Staff also arranged for local faith representatives to visit when requested by patients and carers.

Listening to and learning from concerns and complaints

- Information from the provider showed in the 12 months to December 2017, there were 10 complaints. Two had not been concluded, one had been upheld, two had been partially upheld and five were not upheld. No complaints had been referred to the ombudsman.
- Most patients told us they knew how to complain. Information about how to make a complaint was displayed on notice boards and staff supported patients to make complaints when they wished. The independent advocate also supported patients to make a complaint.
- We looked at two complaints. Responses were made within two days or less and investigations took place promptly. We saw evidence that actions were taken as a result of the complaint and that the provider apologised. When a patient made a complaint, they received a quick response and were give an easy read version of the outcome, which was also explained to them by their named nurse. However, responses lacked detail and a meeting was not offered in either record, which is contrary to the provider's policy.
- Staff received feedback from complaints through team meetings, handovers or through individual supervision where appropriate.

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

Good

Vision and values

- Since the merger with the Priory Group, the company's visions and values were represented by the seven c's: care, compassion, competence, communication, courage, commitment and consistency. Most staff were not aware of this but said they wanted to offer high quality care to patients and move them on to less secure placements where possible and appropriate.

- Staff knew who senior managers were at the service and told us they visited the ward regularly. Staff had limited knowledge concerning more senior managers in the organisation.

Good governance

- Managers used key performance indicators and targets to measure and improve the performance of the team. The provider had effective systems in place to demonstrate whether staff had received mandatory training, supervision and appraisals. Managers used spreadsheets, which showed when staff needed training refreshers and updates. They used these to ensure staff remained compliant with mandatory training and supervision.
- The provider had a system in place on Fridays whereby there were additional members of staff on duty to facilitate training and help staff keep up to date with administrative tasks.
- The provider had systems in place to monitor staffing levels to ensure that the service was staffed safely and that any shortfalls were quickly identified and acted upon. The provider had ensured that shifts were covered safely and had built in additional capacity for staff to complete other duties. This meant that there were sufficient staff to ensure that patient care was not compromised.
- Managers had prioritised recruitment and operated an ongoing recruitment programme. While recruiting suitable staff remained a significant challenge, the provider had blocked booked agency staff to increase numbers of staff who were familiar with wards and patients. This ensured continuity of care for patients at the hospital. Four healthcare workers were being supported to complete nursing training.
- The provider had systems in place to ensure registered nurses completed their revalidation and ran a local preceptorship programme for new nurses.
- The provider had processes in place to measure the quality of the service. We saw audits, for example of seclusion documentation and section 17 leave, which reviewed practice and identified actions required. The provider also monitored incident reporting to ensure learning took place in response to these. The registered manager conducted "quality walkabouts" on the wards and had overseen a number of environmental improvements to upgrade the wards, for example the en-suite bathrooms.
- The provider had not ensured that staff recognised or recorded incidents of prone restraints during seclusion. We reviewed closed circuit television showing four incidents of seclusion and saw staff placing patients in the prone position to allow for a safe seclusion exit. We raised this with the provider who circulated a memo instructing staff to ensure that where prone restraint was used as an exit technique, this must be recorded. We checked one seclusion record after this circulation and found that staff had appropriately recorded the use of a prone restraint.
- Safeguarding was reported appropriately and the provider had good processes in place to monitor investigations, working closely with police and the local authority safeguarding team.
- Systems were in place for staff to learn from incidents, complaints and audits through monthly lessons learned bulletins, team meetings, handovers, early morning review meetings, supervision and debriefs.
- Managers told us they had sufficient authority and support to complete their role. They were able to submit items to the service's risk register through the registered manager.

Leadership, morale and staff engagement

- The provider did not collect sickness and absence rates for this service by wards. Data from the provider stated that he overall sickness rate for the hospital was low at 2% between 1 January and 31 December 2017.
- There were no bullying and harassment cases at the time of inspection.
- Staff were aware of the whistleblowing policy and said they felt confident to raise issues if they came across poor practice. Staff said they felt managers would support them if they did.
- Staff said that morale was good and that staff teams supported each other effectively and worked well with patients. Team members worked closely with each other and with multidisciplinary staff. For example, psychologists and the speech and language therapist contributed to ward teams in undertaking debriefs to staff and patients, which staff said they found helpful. Staff told us they felt supported by managers and could come to them for support when they needed it.
- Staff told us they had opportunities for development. The provider publicised opportunities through their newsletter. One staff member gave an example of a leadership course they had been supported to attend.

Good

Wards for people with learning disabilities or autism

- Staff gave feedback about the service through team meetings, supervision and the staff survey.

Commitment to quality improvement and innovation

- The provider was a member of the quality network for forensic mental health services. Overall, it met 91% of the standards, an increase over the previous year.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff recognise and record when prone restraint techniques are utilised on patients to enable staff to exit safely from seclusion rooms.
- The provider must ensure that all patients in prolonged periods of seclusion receive four hourly medical reviews, in accordance with the Mental Health Act code of practice.

Action the provider SHOULD take to improve

- The provider should ensure that all ligatures are recorded on the ligature risk assessment and that staff are aware of how these risks should be managed.
- The provider should update risk assessments regularly and after incidents.
- The provider should ensure that patient involvement in all risk assessments and care plans is documented.
- The provider should ensure that all emergency equipment is safe for use.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that staff recognised and recorded when prone restraint techniques were utilised on patients to enable staff to exit safely from seclusion rooms. • The provider had not ensured that all patients in prolonged periods of seclusion received four hourly medical reviews in line with the Mental Health Act code of practice. **This was a breach of regulation 12**