Gloucestershire Health & Care NHS Foundation Trust

Wards for people with a learning disability or autism

Inspection report

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Date of inspection visit: 10 and 11 October 2023
Date of publication: 01/03/2024

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Wards for people with a learning disability or autism

Inadequate 

Gloucestershire Health and Care NHS Foundation Trust provides community, physical health, mental health, and social care to the population of Gloucestershire.

Gloucestershire Health and Care is a Foundation Trust, which means they are not directed by the government but are accountable to the local community through their members and governors who live and work in Gloucestershire and beyond.

During this inspection on 10 and 11 October 2023, we visited Berkeley House, a stand-alone unit for people with a learning disability located in a residential housing estate on the edge of the town of Stroud.

During this focused inspection we inspected the safe, caring and well led domains as well as parts of effective and responsive due to having received concerns raised by the Trust around the care and safety provided to patients at Berkeley House.

We rated this service as inadequate because:

- People's care and support was not provided in a safe, clean, well equipped, well-furnished, and well-maintained environment. The service did not always meet people's sensory and physical needs.
- The service failed to review and monitor significant restrictive practices and consider how they could be reduced. However, staff had commenced the HOPES (harness, opportunities, protective enhance system) training to support their knowledge in restrictive practices.
- People who used the service were not supported to be independent and have control over their own lives. The service was unaware how significant restrictions on people's human rights and freedom may impact on their wellbeing.
- There was best interest decision documentation regarding the use of CCTV in all service users' records, but staff did not always follow the provider's policy regarding its usage. The monitor recording the CCTV was visible to visitors. This did not protect the person's privacy, dignity, and risk of abuse.
- The service did not have the service of a psychologist for over 2 years. The Trust however had psychology input which was provided from the Community Learning Disability Team on a regular basis by referral.
- While people were given choices, the care records identified a lack of activities taking place which meant people were not partaking in their planned care and were not being supported to achieve their goals. The behavioural analysis plan for each person was not reviewed and updated.
- There were systems and processes to safely prescribe, administer, record and store medicines. Staff members did not always adhere to them during the inspection. Health care assistants were administering medicines which were not in line with the Trust's guidance. The electronic administration records identified numerous gaps in the administration of medicines. There was no managerial oversite to manage concordance. Some patients were prescribed "as required" medicines with no oversight to the reasonings why or whether this was effective.
- Staff did not always receive regular supervision.

Our findings

- The weekly multidisciplinary team meetings did not always work well. Staff did not always work well together to provide the planned care required for each person.
- People did not have clear plans in place to support them to return home or move to a community setting. Following the inspection, the Trust informed us all patients had received a discharge plan.
- There was not a recognised model of care and treatment for people with a learning disability or autistic people. Monthly quality assurance data were completed and analysed but the management team did not always pick up issues on compliance which meant they were not aware of how the service was performing.
- Outcomes data and quality improvement opportunities and evidence-based policies and procedures were reviewed within the clinical governance framework. However, staff spoken with said they did not know how well the service was performing because information was not disseminated and shared with them.
- The service failed to analyse incidents comprehensively to consider triggers, themes, and trends and how incidences of distressed behaviour, and restrictive practices could be reduced. Records seen did not identify key themes and trends to mitigate the risk or reoccurrences of distressed behaviour or to reduce restricted practices imposed.

However:

- People had their communication needs met and information was shared in a way that could be understood.
- People's risks were assessed regularly, and people's care and support plans reflected their sensory cognitive and functioning needs.
- Staff ensured that people had regular contact with their families.
- People had access to advocates when required.

Information about the service

The core service was last inspected in April 2022 and was rated as good overall.

Berkeley House is a service for people with learning disabilities and autistic people who may be informal or detained under the Mental Health Act 1983. Accommodation is arranged into 7 individual flats. At the time of the inspection 6 of the flats were in use. One person was under 18 and 5 were aged over 18.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The service had to demonstrate how they were meeting the underpinning principles of Right support, Right care, Right culture.

Right Support: The provider was developing a model of care that ensured people's stay was not prolonged to enable them to live successfully in the community with support and prevent admission to hospital.

Right Care: People's care was individualised, planned, and delivered in a manner that met their needs. People's care promoted their dignity, privacy, and human rights.

Our findings

Right Culture: Staff were supporting people with their transition to live successfully in the community. They were respectful to the people they supported.

The Trust is registered for the following regulated activities:

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

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

People were accommodated in single ensuite flats. There was restricted access to their outdoor space.

We found that some of the flats needed major repairs. There were boarded up windows and doors. Two of the flats visited were stark with limited personalisation. This was not in line with the Trust's Segregation of Patient's guidance for Berkeley House which states that the flats should "replicate potential pre and post discharge community placements which patients would aspire to if given the choice. They should provide low stimulus environments that encapsulates the opportunity for choice, meaningful activity and encourage greater independence." Managers told us quotes for the boarded-up windows were due soon and the service was waiting for stronger door frames to be installed. There was no allocated date for this to take place.

Staff told us the door locks within the flats were not always safe which meant people could get out and access areas such as the kitchen or outside space. We saw evidence of incidents where people had left their flat and required support to return to the location. We saw that doors designated as fire doors were bolted from the outside which meant there was a risk of people being left unsafe in their flats. However, the management team informed us the fire safety officer had assessed the temporary measures in August 2023 and were satisfied the service met the health and safety requirements. We noted that these were reflected in the people's Personalised Emergency Evacuation Plans (PEEPs).

The fire report had identified comments for the management team to address. These included the carrying out of a departmental fire drill every six months and the cleaning of tumble dryer filters to reduce the risk of fire. We did not see evidence that these concerns/issues had been addressed.

In the young person's flat, there was a missing switch from the wall and there was a metal knob protruding. This could be hazardous to anyone who slipped and fell against it. Following the inspection, we received confirmation this had been addressed.

Safety of the service's layout

While there were potential ligature anchor points within the service, these risks had been mitigated to keep people safe.

Our findings

An anti-ligature product reduces the risk of self-harm through strangulation by making it as difficult as possible to secure a cord or other material in place. Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe. Staff could also observe people and protect them using CCTV cameras.

Staff completed and regularly updated the risk assessments for all flats, and removed or reduced any risks they identified.

Staff had access to alarms. All staff were equipped with personal alarms which were linked to an alarm system.

Maintenance, cleanliness, and infection control

The physical environment was not appealing and did not always meet the person's sensory and/or physical needs. The flats were poorly maintained with poor fixtures and fittings. Some people had limited access to outside space.

We visited 3 flats. They looked clean, but one had a bad odour which staff said was difficult to eradicate. It was acknowledged that 1 person routinely smeared faeces and this added to the challenge of removing odours in the flat. Two of the flats had hardly any furniture. The furniture included a bed, a "pod", which is a large bean bag, and cushions or foam blocks. One patient's bed was a mattress on the floor. We questioned the rationale regarding the lack of a bed base and whether this had been escalated to the management team. Staff had not escalated the concern and told us the person was using the mattress due to damage caused to be bed base. We raised this concern with the matron, and a bed base was immediately replaced. Staff were unable to tell us what processes they had to support people who spent long times in their flats with limited furniture. Following the inspection, the Trust confirmed they had speeded up the ordering of additional furniture and items to improve the person's living spaces.

Each flat had its own individual garden area. However, during the inspection we saw some of the garden areas were restricted due to damage to fences, tiles, and gates. Staff said it was unsafe for the patient to access the garden. We did not see any plans for when these would be resolved. Following the inspection, the Trust informed us locks on garden gates were immediately addressed and had been resolved. They informed us they continued to review the replacement of broken tiles and fences.

Staff spoken with said they did not think the buildings were robust enough and it took too long to get repairs sorted. In response to staff concerns the Trust informed us they had instigated monthly meetings between the management team and estates which would expedite repair requests. They provided us with a copy of the latest monthly meeting minutes and action log. Areas covered included a review of each flat, the site and staff areas.

The infection prevention and control (IPC) team were currently visiting the service weekly. Concerns had been raised regarding the cleanliness of the flats and the management of infection control across the service. Examples from the report identified cookers needing cleaning, the inability to clean grills in the window and alarms not sounding in one of the flats. Each issue had an identified plan and who was responsible for the outcome.Cleaning responsibilities and schedules were being drafted to ensure cleaning was undertaken and staff were aware what was required.

The delay in completing repairs meant there was increased infection control risks, for example, non-wipeable material being used for boarded up windows. To mitigate the risk the service was holding monthly meetings between the matron, unit manager and the estates and facilities team. A monthly contracted deep clean was arranged alongside enhanced cleaning being carried out by clinical and housekeeping teams. During the inspection, we found improvements had been made which was also reflected in the audits seen.

Our findings

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment where applicable.

Safe staffing

The service had enough staff on duty to deliver people's care and treatment. Staff did not always understand the person's needs but were currently receiving additional training to keep people safe from avoidable harm.

Nursing staff

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The number of staff assigned to work with the person was dependent on their individual needs. While the service was reliant on agency staff due to staff shortages, the rotas seen showed there were enough nursing and support staff to keep patients safe. Relatives said they felt there were enough staff assigned to work with their family members. They were aware that staffing numbers could be increased if their dependent became anxious or when organised activities were planned. They also told us there were many staff whom they had not met before which made it difficult for their relative to have continuity.

The management team confirmed that staffing levels had increased but there continued to be staff vacancies, which currently was at 26%. They told us that every effort was made to cover vacancies including deploying staff to support individuals where there was a need for higher staffing levels. The management team were also undertaking shifts to support the staff team. We observed this during the inspection when the matron was part of the daily shift.

There was a speech and language therapy vacancy which the service had not recruited to. This post had been out for recruitment several times but had been unsuccessful. Senior staff raised this as a concern to us during the inspection. However, there was a process in place for referrals if required.

Managers supported staff who needed time off for ill health. Levels of sickness were high at 12%. Staff described measures to reduce turnover and sickness. Back to work interviews were held with staff returning from absences.

Managers made sure all bank and agency staff had a full induction prior to starting their shift. This was confirmed by an agency staff we talked with.

The service had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough daytime medical cover. The service had access to 24-hour cover, and a doctor was available to go to the service quickly in an emergency.

Relatives said their family members had access to medical staff as needed.

The Responsible Clinician for this service was an experienced learning disability consultant psychiatrist who worked alongside core members that made up the multi-disciplinary team (MDT).

Our findings

There was a longstanding psychology post vacancy. Following the inspection, the Trust informed us that they had accelerated the recruitment for the psychology vacancy and were redirecting some time from the community learning disability psychology team to support the service.

Mandatory training

Staff had completed and kept up to date with their mandatory training. This was confirmed by both the manager and staff we spoke with. Staff told us their training was mainly done online.

Managers monitored mandatory training and alerted staff when they needed to update their training. During the inspection we found that the staff we spoke with were not aware of restrictive practices and how they could be reduced. In response to staff concerns the Trust confirmed they had commenced HOPES (harness, opportunities, protective, enhance, system) training which specifically focuses on reducing restrictive practices and improving quality of life. Currently 40% of staff had completed the training with further training booked for 20 and 21 November 2023. A practitioner will provide face-to-face monitoring after the training to support staff in the recognition of interventions that can reduce segregation and restrictive practices.

Managers said they could book and arrange training when required. Staff were aware of what training was required of them and they were prompted to attend training when it was available.

Staff had undertaken Positive Behaviour Management training, which enabled them to support people whose behaviours at times placed them and others at risk of harm. Relatives felt the staff's approach was beneficial in keeping their family member safe.

During the inspection the safeguarding team confirmed they were working alongside the 'Freedom to Speak Up' lead to provide training sessions on civility.

Managers shared that staff employed by the Trust had started to undertake training in supporting autistic people and people with a learning disabilty.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff used restraint only after attempts at de-escalation had failed. While the service participated in the provider's restrictive interventions reduction programme this was not observed to be in place during the inspection.

Assessment of patient risk

Staff completed risk assessments for each person which were reviewed regularly. Staff described the person's individual risks and the actions needed to reduce or remove the risk.

Records seen had an up-to-date risk assessment and risk management plan which contained sufficient information to support the individual person's needs and risks. However, we noted that actions identified from the multi-disciplinary meetings were not reflected which meant there was a risk of staff not following procedures in the best interest of the person. There were also no psychological assessments to ensure future planning and longer-term aspirations were identified for each person. Each person had care plans. These were not individualised and did not address all aspects of the person's activities of daily living and treatment. There were no identified goals for each person to achieve in

readiness for discharge to their long-term home. There was no evidence these had been shared with family members where they had the legal right to see them. The Trust informed us following the inspection that they had contacted all families regarding individual changes made to care plans. They also said family members would be given the opportunity from the second week of November to meet with the matron to review care programmes.

Staff could describe how they supported the person's individual communication needs which included the use of symbols, or specific words.

Management of patient risk

While staff followed Trust policies and procedures when they needed to keep people safe from harm there were no psychological assessments in place.

The occupational therapy support plan was informative and provided guidance on hobbies or interest each person enjoyed. Behaviour support plans in place recorded the person's preferences, individual risks and their communication needs. The plans provided essential information to ensure that new or temporary staff could reduce the likelihood of someone having a difficult day by following how best to support them.

Staff knew about each patient's risk and care plans supported access to vehicles and visits to the community. However, we found staff provided overprotective care even if well-intentioned. Staff did not always encourage engagement in hobbies or interests due to the perceived risk. For example, one patient had not undertaken any activity for 14 days while another had only had 6 activities in 31 days. There was no evidence within the records to provide a rationale for this.

There was no evidence of choices being offered or tailored to the person's individual needs. Staff did not always support people's independence in planning their day or week. Staff did however ensure that people had access to their relative through home visits or phone calls.

Families were encouraged to be involved in discussing their family member during multi-disciplinary team (MDT) and Care and Treatment Review (CTR) meetings. Following the inspection, the Trust told us they had made a request to an external body to have CTR's reviewed on site.

The assessments did not have psychological input and did not include future planning or consideration for the longer-term aspirations of each person. The service did not collect data on how people were progressing with activities of daily living. There was no evidence of continuous learning or skills teaching conducted by staff. Rather than teaching a skill, staff were doing the task for the person. Following the inspection, the service revised all positive behavioural support plans, restrictive interventions, and discharge plans. These would form a weekly report produced by the Trust's behavioural support team and be presented at the weekly MDT.

Following the inspection, the Trust told us they had increased activities on and off site which would be reviewed daily and evidenced through the progress notes. This also included checking that actions agreed at handover were being implemented throughout the shift and were understood by the team.

Staff knew the people they were supporting including their health and wellbeing needs. Staff said they could request access for review by medical staff as well as external health professionals when required. Staff used NEWS2, a recognised escalation tool, to assess physical health.

Relatives said the staff organised medical care and accompanied their family member on appointments as needed.

Our findings

Staff explained how they would search individual bedrooms to keep them safe from harm if required. There was a search policy for staff to follow.

Use of restrictive interventions

The service did not have a separate seclusion room. All people using the service remained in their flats when restraint/ restrictions were imposed. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed the Mental Health Act Code of Practice guidance as all patients at Berkeley House were classed as being in long-term segregation.

The management team informed us there was a clear commitment to minimise restrictive interventions. However, during the inspection we did not see evidence of clear reducing restrictive intervention plans in place. There were also poor records for monitoring this. Staff we spoke with said there was no alternative and adopted restrictive interventions first. There was no evidence of reflective practice or debriefs post incidents.

Staff did not always record when a person was in seclusion accurately. The management team told us that all people using the service were on long term segregation (LTS). LTS refers to a process to reduce a sustained risk of harm posed by the service user to others. When staff withdrew from the flats due to concerns with the person's behaviour, the Trust's seclusion guidance was implemented. The guidance says that seclusion should start after "90 minutes of no interaction with staff." Managers recognised that the design and delivery of health care in single occupancy wards could result in potential segregation. We asked the matron how they were assured when the segregation countdown time started. They told us this was recorded on the observation charts and that the nurse in charge would know when staff had withdrawn. We checked the observation charts over the two inspection days for two patient who had been in their flat on their own. The observation charts did not identify the time when staff withdrew from the flat. This was also confirmed by staff we spoke with. This meant there was the likelihood that people may be placed in seclusion without any formal decision making or review.

Staff did not always complete observations for people in seclusion in line with the Trust policy or defined guidance. The Trust policy states that the patient's behaviour and condition should be observed continuously by a member of nursing staff throughout the period of seclusion with recorded details. This was not reflected in the records seen. We reviewed the observation chart of a patient where it indicated this should be recorded every 5 minutes. This was not being completed correctly which meant there was the potential risk of staff not adequately supporting the patient's individual needs.

Staff did not always consider the least restrictive options before limiting people's freedom. We observed that individuals were not free from unwarranted restrictions with most staying in their flats. Access to the garden areas was often restricted with staff saying this was due to the damage caused by people using the service. The Trust informed us they were waiting for essential repairs to make the garden area safe.

All people using the service had Section 17 leave which had been agreed by the responsible clinician. A detained patient is only allowed to leave the service when a Section 17 leave is in place. Staff told us they often restricted the person's freedom, choice, and control over their lives and the records seen identified people spent a large amount of their time within their flats. There was very little evidence from the care records that people utilised their Section 17 leave. Staff could recognise signs when people experienced emotional distress and knew how to support their safety. However, the person's movements were often restricted with staff encouraging them to remain in their flats. Staff were unable to provide us with the reasoning for the long lengths of time people stayed in their flats.

Our findings

The service monitored long term segregation via 3 monthly reviews but informed us they had not considered reviewing if a person using the service had inadvertently been secluded. Examples of areas reviewed included medicines, physical intervention plans. CCTV usage and discharge planning. The Trust told us that all future reviews would review the impact long term segregation may have on the person's emotional wellbeing.

The Trust updated the monitoring sheet to include a start and finish time to enable them to accurately record the length of use of CCTV cameras. As part of the new patient safety huddle this process would be reviewed throughout the shift. The Trust said they had also developed an additional drop down on their electronic incident system and this would provide additional information to review and support. A weekly behavioural management audit was being completed and this information would be shared with the clinical team.

Following the inspection, the service increased the documented behavioural analysis to review the reduction of restrictive practices. Opportunities to reduce restrictions would be featured and discussed in enhanced handovers and safety huddles. The Trust said they would oversee the effectiveness of this process.

Safeguarding

While staff understood how to protect patients from abuse and the service worked well with other agencies to do so, they failed to recognise restrictive practices and report them. Staff used restrictive practices by limiting their person's rights and preventing them doing behaviours which may cause concern.

Prior to the inspection, the Trust informed us that they had started a safeguarding led investigation to review concerns received. Allegations related to staff conduct and quality of the care provided. During the inspection, we found the service had failed to ensure people who use the service were protected from abuse.

Speaking up was taken seriously and the Trust ensured all staff were supported.

The Trust informed us they had instigated additional safeguarding visits, staff sessions, freedom to speak up visits and drop-in sessions.

Commissioners have refreshed their reporting and supervision of the independent supporter who visited the service.

Staff received training on how to recognise and report abuse. Staff kept up to date with their safeguarding training with 90% of staff completing the training relevant to their role.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. They explained the process to follow if they recognised abuse. Data provided identified there had only been one safeguarding referral made since June 2023.

Staff access to essential information

Staff had access to clinical information – whether paper-based or electronic. Staff did not always write important information in records, and managers did not complete audits.

While staff could easily access patients notes we found they were not comprehensive. In the five records we looked at, staff had not recorded important information. They had not, for example, recorded the reasons for using CCTV cameras, what activities had been ongoing, or why a person had remained in their room throughout the day when their baseline did not suggest they were having a difficult day.

Our findings

Managers told us they did not undertake audits of care records to ensure completeness and accuracy. Following the inspection, the Trust said they had completed spot audits on the progress notes and said they could see significant improvements in the quality and standard of note taking following the inspection.

The Trust told us they had also implemented a proforma in the progress notes around communication strategies and this would be initially audited daily to understand what was useful. This was to ensure that documentation was standardised and that actions had been implemented. This would give additional assurance that non-abusive care was being consistently delivered and documented.

Records were stored securely.

Medicines management

The service used systems and processes to prescribe, administer, record and store medicines. However, we found that staff did not regularly review the effects of medicines on each patient's mental and physical health. Concerns with the management of medicines was also identified as a concern in the March 2022 inspection.

There was a medicines management policy in place for staff to follow. Medicine audits were conducted by an external pharmacist.

Medicine management had been identified by the Trust as an area of concern. Their action plan for July 2023 requested that the pharmacy team and a senior nurse reviewed the medication practice at Berkeley House.

Staff did not always follow a person's care plan when administering covert medication. Covert medication is when staff administer medicines without the patient's knowledge or consent, for example, disguising it in food or drink without their knowledge. The care plan for one person, for example, provided clear guidance on how to give the medicines and outlined that administration was the responsibility of the nurse in charge. During the inspection, we found that covert medicines were being administered by health care assistants (HCA's) with no oversight by the nurse in charge.

HCAs administered a medicated cream without any training or competency assessment. They told us that knowledge about cream administration passed down verbally from HCA to HCA with no written instructions. This process was also confirmed by nursing staff and was brought to the attention of the management team.

This concern was brought to the attention of the management team. They informed us that their policy on ordering, prescribing, administering, storage and handling of medications (POPAM) would be discussed and added to the next POPAM review. They would also ensure that clinical area managers were meeting the criteria of POPAM, and had competency assessed the HCAs in relation to medicine administration. A register would also be maintained to ensure staff's competency in addition to a required log entry within their personal file.

Nurses did not always order important medicines. Medicines prescribed for agitation was out of stock on 2 occasions resulting in 5 doses being missed. This was discussed with the pharmacist who was unaware of the problem. The pharmacist confirmed nurses were not good at ordering in advance. The dispensary did not deliver on the same day, and this could be a reason doses were missed. This meant that the Trust did not have oversight of medicine management to ensure there was sufficient stock available to manage a person's symptoms. Following the inspection, the Trust informed us they would raise our concern at the next pharmacy staff meeting. Additional reminders were being provided to nursing staff around the early ordering of effective quantities of medicines to mitigate this risk in the future. They have reminded staff about accessing the on-call pharmacist for any out of hours requests. This would be reiterated to all staff during handover to ensure it is embedded.

Our findings

Staff told us they did not carry out any rapid tranquilisation on patients. However, during the inspection we found rapid tranquilisation medicine in the fridge and staff informed us they had administered this medicine to support a patient who needed to visit the hospital. Following the inspection, the Trust informed us this incident occurred approximately 2 years ago and that the items in the fridge were stock items and not patient specific. Actions undertaken by the Trust following the inspection included training for clinical area managers and their deputies to ensure the timely ordering and removal of medicines when not in use.

The missed dose audit from 1 to 23 July 2023 identified missed doses as a concern. We reviewed the medicines from September to October 2023 and found medicines were often recorded as being refused with little attempt to try again after refusal, so people who used services were at risk of not receiving essential prescribed medicines. For example, we found a total of 115 missed doses during this time for three people. This meant that the administration of medicines was not effective. There was no evidence that different strategies had been attempted to increase the concordance with medicines. Following the inspection, the Trust informed us they had developed a progress note template which clearly sets out any medication that was given or not given and this would be handed over between shifts. This information would also be used to inform the MDT. team.

While staff knew about achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism, or both), the service did not always ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines. Sometimes medicines may be required to be given 'as required." This medicine can be used to treat many different conditions and is usually prescribed to be used short term and not to be taken regularly. From the records seen we noted that "as required" medicines had been used a total of 29 times for one patient from September to October 2023. There was no evidence that other least restrictive options had been considered prior to administration or whether the use of this medicine was beneficial. The MDT meeting minutes for 20 July 2023 also identified the high usage of as required medicines and had considered if this medicine was addictive. There was no follow up documentation evidenced or any outcomes to the concerns raised. We asked the Trust to provide us with reassurance regarding the use of "as required" medicines. Following the inspection, the service reviewed all medicines and confirmed alternatives had been introduced to help manage impulsivity and irritability. The service had introduced a form, which included specific prompts to remind staff to record reasons for use, the monitoring, and the effect the medicines were having. The management team were reviewing records daily to monitor staff recording. The Trust said that spot audits of records had shown improvement in the quality of note taking.

A metal cabinet used to store the patient's medicines was locked when not in use. At the time of the inspection there were no controlled drugs that required safe custody. However, we noted that this cabinet was not bolted to the wall which did not meet the Misuse of Drugs (safe custody) Regulations. This was brought to the attention of the matron during the inspection who confirmed they would address our concerns.

The service had a dedicated clinic room where all medicines were stored. This room was also used for CCTV camera observations. We noted that doors to the room were locked when clinical staff were not there.

All medicines checked were found to be in date. Maximum and minimum fridge temperatures were measured and recorded daily and were within the approved guidelines.

All people who used services had received a Flu/Covid vaccination. This process was undertaken over several weeks to accommodate the person's behaviour, presentation, and relative's wishes.

Staff did not always complete Mental Health Act medicine forms with the correct information. This was due to a problem with the Trust's electronic records system. If the Responsible Clinician (RC) believed that the patient lacked the mental

Our findings

capacity to consent to their medication or if they believed the patient had the mental capacity to consent to their medication but was refusing medication, a Second Opinion Appointed Doctor (SOAD) would be responsible for the completion of a T3 form. We reviewed the T3 documentation and found discrepancies with the maximum dosage of one medicine. We discussed this with the Trust who informed us there were limitations within the electronic system for setting specific times. Actions taken to manage this included training and mandating clinicians to use the comments box for additional instructions when prescribing. The Trust had changed the medication administration screen so that additional information boxes were visible when administrating. The Trust alongside 2 other mental health providers have submitted a change request to the software provider regarding this concern.

Track record on safety

Reporting incidents and learning from when things go wrong.

The service had a process to manage patient safety incidents. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers did not analyse trends to identify key themes.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with Trust policy using an online incident reporting system. Staff were aware on how to report issues that included for example, patient altercations, any accidents, and anything untoward.

Records seen provided an overview of how many incidents occurred per month but there was no evidence of analysis to identify key themes and trends to mitigate risks or reoccurrence of distressed behaviour or to reduce restrictive practices imposed. To address concerns raised during the inspection the Trust implemented a daily huddle which took place in between shifts. This included senior management focus on themes and trends relating to distressed behaviour which would be reported to the weekly MDT. All the collated information is to be used to create new behavioural analysis plans for people using the service.

Staff understood the duty of candour. They were open and transparent and gave families a full explanation when things went wrong.

Managers investigated incidents. Patients and their families were involved in these investigations. However, two family members said they did not always feel they were given up to date information in a timely manner and often had to request updates on any investigation.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down.

Skilled staff to deliver care.

The service did not have access to a full range of specialist to meet the needs of people using the service. There was a longstanding clinical psychology post vacancy. Following the inspection, the Trust informed us that they had accelerated the recruitment for the psychology vacancy and were redirecting some time from the community learning disability psychology team to support the service.

Our findings

The service also had a long-term Speech and Language Therapist (SALT) vacancy which they had failed to recruit to. This post had been out for recruitment several times but had been unsuccessful, Staff said they were able to make a referral to the Trust SALT team if needed.

There was a high use of agency staff. Agency staff we spoke with confirmed they attended two day's full induction prior to working at the service.

Staff did not always receive supervision and the figures seen showed only 60% of staff had received supervision. Staff told us supervision was ad hoc and was not constructive. This was brought to the attention of the management team who said they would review our concerns.

Managers did not ensure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care. For example, during the inspection we observed health care assistants administrating medicines without having the appropriate skills. There was no evidence of the nurse in charge oversight as outlined in the individual person's care plans.

Multi-disciplinary and interagency teamwork.

We found staff from different disciplines did not always work together as a team to benefit people who use services. They did not support each other to ensure there were no gaps in their care.

Multidisciplinary team (MDT) meetings were held weekly, and discussions alternated between positive behaviour support (PBS) plans and patient orientated meetings (POMS). External stakeholders said that health care workers from Berkeley House rarely attended meetings and the communication book completed during MDT was ineffective. This was confirmed by staff we spoke with who said they rarely attended an MDT meeting.

Staff did not always follow plans developed at MDT meetings. We reviewed weekly MDT meetings which outlined actions for staff to follow. During the inspection, we found these actions were not always being followed by the staff team. For example, staff were not recording a patient's diet when requested or another person's sleep pattern. This meant the service was not following identified concerns to manage the patient's best interest. Following the inspection, the Trust told us they had immediately implemented an improved process to disseminate decision from the MDT to all staff via their handover process. In addition, they had introduced a safety huddle in between each of the three-shift system which would enhance and ensure all critical information was exchanged between shifts.

Staff did not have effective handovers. They did not share information about patients and any changes in their care. We observed a staff handover which was not very informative to ensure people's safe care and treatment. The handover was very short and only provided a brief overview of the individual's overnight. The handover did not discuss any activities for the day. Visiting staff told us they had attended handovers which they found to be mechanical and impersonal and lacked respect when discussing patients.

Changes to people's outcome and actions arising from multi-disciplinary meetings were not shared with staff during handover meetings. These were not reflected in the daily progress notes. Following the inspection, the Trust informed us they had updated the handover sheet to ensure it included person centred goal settings which would be reviewed at the end of the shift. Daily huddles had been put into effect in between shift handovers to include estate issues, incidents and staffing levels. Action plans were also to be reviewed for people who use services.

Our findings

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion, and support

Staff did not always respect the patients' privacy and dignity. They failed to understand the individual needs of patients and did not support patients to understand and manage their care, treatment, or condition.

Staff did not always understand and respect the individual needs of each patient. Staff did not follow Trust procedures when they observed patients via CCTV cameras. CCTV cameras were used to observe individual people when staff had to withdraw from situations where there was a potential risk of harm to the person or others. Concerns over the use of CCTV cameras were highlighted as a concern in the March 2022 inspection.

The CCTV was within an office used for storage as well as the medicines clinic room. This office was accessible to anyone with a key fob, and they could access the CCTV at any time. We observed staff were not compliant with the Trust's guidance. The care records did not reflect when CCTV was being used and we saw one patient had 5 cameras within their flat which could be viewed by anyone who had access to the CCTV recording. Staff confirmed that external visitors often visited the CCTV room which meant they could view inappropriate images. The Trust told us they were looking at purchasing screen privacy overlays that would prevent indirect viewing.

Following the inspection, the Trust updated their CCTV Standard Operating Procedure, provided new signage and a reminder to staff that camera images were not to be visible when leaving the clinic room. Spot checks were to be introduced to ensure compliance.

Care plans did not outline that as well as staff other people could view the CCTV cameras. Staff informed us those visiting personnel had access to the CCTV room with no restrictions. The trust informed us they had reviewed all care plans and where appropriate, the service had introduced easy read scripts to support the patient's consent to the use of the CCTV.

The amount of CCTV observation being monitoring were also to be reported to and viewed by the MDT each week to look at themes and trends to enhance each person's quality of life.

Two of the windows in the family room did not have blinds. Staff told us these had been removed to ensure the safety of individuals and staff when they utilised computer time. This meant that anyone using the room could not have privacy. We were informed they were planning to have privacy screen placed on the windows.

We were unable to obtain people's feedback during the inspection. Some people declined to speak to us while others were unsettled. Staff informed us that it was in the person's best interest for us not to exacerbate their anxieties. Relatives praised the staff for their care they provided to their family members. They said staff knew the person and knew how to support them.

Staff we spoke with were passionate and caring. They knew their patients well and some were able to articulate how the people's care could be improved.

Our findings

We saw people responded to staff when they engaged with them. We observed good interaction and communication skills when engaging with people. Relatives confirmed their family member worked well with specific staff they "liked."

Involvement in care

Involvement of patients

Relatives said they were involved in their family member's care planning. The care records did not identify people's involvement in their care planning and risk assessments. Most care plans were impersonal and did not identify what the patient's wishes were. Following the inspection, the Trust informed us they had created easy read information to obtain the person's consent for the CCTV recordings

Staff told us an advocate visited the unit on average every three weeks. The records seen did not identify feedback from the independent advocate and how they were supporting the individuals to make decisions.

Staff were unable to tell us how they obtained the person's feedback about their experiences of care.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers.

Staff helped families to give feedback on the service.

Is the service well-led?

Inadequate 🔴 ↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

Following the inspection, the Trust reviewed the management and leadership skills at Berkeley House. The service was provided with additional support from a senior nurse manager, an advanced nurse practitioner and the Ttrust's medical director.

Berkeley House is managed by a unit manager with oversight from a matron. Both were based on site. The unit manager post had been vacant since April 2022 following the promotion of the post holder to matron. The manager was seconded into this post in April 2023.

Following the inspection, the Trust informed us they had reviewed the management and leadership structure at Berkeley House. The matron's role had been restructured so they could focus solely on Berkeley House. A senior nurse manager had been placed into the service to support clinical leadership which enabled them to spend more time in direct clinical work with the patients and care staff.

Staff told us the location of the manager and matron's office meant that they felt that senior staff were distant and uninvolved in the day-to-day care delivery. Most staff said they did not always feel they were heard and lacked

confidence in the management's ability to address any concerns. The deputy manager's office was also away from the main nursing office which meant they may not have clear oversight of any concerns arising. The occupational therapists were not located within the main clinical areas which may affect clinical relationships and the opportunity to role model good care.

While the management team said they had an open-door policy for informal discussions, advice and support, most staff we spoke with said they did not feel safe at work, did not feel supported and were not confident in approaching the management team if they had any concerns.

Staff reported that debriefs and supervision were not robust and often did not occur. Supervision figures were poor at 60%.

The advance nurse practitioner (ANP) for learning disabilities and autism was working regular and frequent shifts to role model good practice in patient areas. They were also leading on behavioural analysis work while directing increased therapeutic activity.

The Trust's medical director was also providing additional support to the service's psychiatrist.

Vision and strategy

Most staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The Trust's mission of "enabling people to live the best life they can", was supported by their vision of "working together to provide outstanding care." This was underpinned by the Trust values of, working together, always improving, respectful and kind and making a difference.

Managers were clear on how well the service was developing and while access and demands were on occasions challenging, they could outline how they provided support to patients when required.

Culture

Some staff did not feel respected, supported, and valued. However, they said the Trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

Following whistleblowing concerns the Trust commissioned an internal review focussing on the CQC 'Well Led' key line of enquiry. The report raised issues with the management of the service who were seen as not always being trusted, responsive or visible. This was reflected during the inspection with staff we spoke with saying they did not always feel able to speak up or have confidence in local management to address issues.

Following their internal review, the Trust informed us they had identified clear leadership and cultural issues that needed addressing within the team. This was confirmed by visiting personnel who said they found staff resistant and were challenging when questioned. Some staff we spoke with said they did not always feel respected, supported, or valued.

Staff said morale was poor and staff did not always eel there was a good culture where staff could share their views without fear of reprisals. Managers confirmed they were aware of the pressure on staff.

Our findings

Most staff told us they did not feel the team worked well together and were not confident that managers would take their suggestions and concerns seriously.

Work had taking place to address concerns raised and to ensure that staff felt comfortable to speak up. Staff we spoke with said they understood the whistleblowing process for raising concerns. We saw evidence of how the Trust had responded to identified concerns and had put an action plan in place to address these.

Staff were aware of the Freedom to Speak up Guardian and knew how to contact them. The Freedom to Speak Up lead had increased the awareness of their role and available support through having an increased on- site presence in areas not only where concerns were raised but also through proactive cultural work. Freedom to Speak Up Guardian champions had been recruited to support the service who were due to start once training had been completed.

Managers confirmed they had processes to ensure there was a culture of openness and transparency. However, staff said they were not confident in raising concerns with their manager or matron and did not feel they would be listened to if they did.

Family members said they felt confident in raising concerns with staff about their relative and the service provided.

The Trust applied Duty of Candour appropriately.

As part of the Trust's commitment to staff wellbeing, they had established a Health and Wellbeing team alongside monthly health and wellbeing newsletters. Staff had access to psychological support if required.

Governance

Managers did not always have effective oversight of quality at the service.

We found that the service's existing service model had changed, and quality had declined since the last inspection. Care and support did not always reflect current evidence-based guidance, standards, and current best practice. This specifically related to meeting the needs of people with a learning disability or autism.

There was not an effective process to ensure that senior staff had oversight of the service. While the service had an audit programme, staff did not always review themes and trends to support the wellbeing of people using the service. For example, we found concerns with the management and administration of medicines. This meant that the service was not picking up on issues in compliance and addressing identified concerns.

Not all care plans were person centred. Staff did not always follow care plans which meant people were not consistently supported to pursue their interests and/or activities.

Staff reported that team meetings were not regularly being held, which was leading to planned care not happening or being adequately reviewed. However, during the inspection, we saw that team meetings had commenced which was confirmed by staff we spoke with.

There was not a clear framework of what must be discussed during handovers to ensure that essential information, such as learning from incidents and complaints were shared and discussed. Staff lateness was highlighted as an area of concern. We observed staff arriving late for handover with little or no consequences. This meant that staff may not have up to date information to enable them to address any concerns or issues that may have arisen and required their attention.

Our findings

Staff told us they did not always work together as a cohesive team. Most said they were unhappy and felt they had not received appropriate training to deal with the patient group.

While there was a clear framework to report incidents these were not reviewed to identify themes and/or trends. Staff said they did not receive feedback from incidents and lessons learned were not shared in team meetings.

Management of risk, issues, and performance

While staff teams had access to the information, they needed to provide safe and effective care, they did not always use this information to good effect. While the Trust provided us with assurances these processes had not yet been embedded into the service.

The nominated individual did not have enough oversight of all the safety concerns and risks. They had not acted to correct all the concerns raised at previous inspections such as the management of medicines and CCTV cameras.

Support was organised around the service's needs rather than the persons. For example, rotas were arranged in a way most convenient for staff. Activities, hobbies, or interests offered were often based on staff availability.

There was not a recognised process for the management of care and treatment for people with a learning disability or autism. Monthly quality assurance data were completed and analysed but the management team did not always pick up issues on compliance which meant they were not aware of how the service was performing.

There was not a balanced support to prioritise daily living needs. Daily living needs for each person did not match the multi-disciplinary approach and plans for each person.

While there was a vast amount of information to meet the needs of patients, care plans were not always timely updated to ensure staff had the most up to date information.

Staff did not plan sufficiently for patient discharge. People did not have clear plans in place to support them move to a community setting. Following the inspection, the Trust informed us all patients had received a discharge plan.

The Trust said they had asked the Positive Behavioural Management team to increase their current reporting and analysis of restrictive practices to provide a weekly summary of activities to the clinical team, the names nurse, the registered clinician, and the multi-disciplinary team. Following the inspection, the Trust provided the CQC with monthly updates to outline how they were assured the risk of restrictive practices were being monitored and managed effectively.

While the service had process to record incidents, there was no breakdown to review trends and themes. We saw examples of the number of incidents, but this information had not been fully analysed to recognise any concerns which needed addressing. Following the inspection, the Trust informed us they had immediately established procedures for the sharing of detailed incident data. This information would also be discussed at the weekly multi-disciplinary team meeting.

Managers had oversight of staffs' mandatory training and supervision. The manager confirmed they ensured staff were able to keep up to date with their training. Training figures seen showed that staff were up to date with their learning.

Our findings

We noted that concerns with the performance of the service had been escalated to Board level. However, we were not assured as to how this information was shared with staff. All staff spoken with said they were not aware of how well they were doing as a service.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure including the telephone system worked well.

Information governance systems were in place included the confidentiality of patient records.

Managers confirmed they had access to information to support them in their role.

Engagement

Managers engaged local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Managers told us they had only recently begun to have team meetings, and this continued to be a work in progress.

Staff said that managers were not always supportive and did not provide clear guidance. Staff were aware of concerns raised against the service. However, most said they felt the visits were not beneficial and wished they could get back to "business as usual."

The service engaged with relatives and carers. Relatives spoken with said they could contact staff should they have any concerns or issues.

Following the inspection, the Trust told us they were actively engaging in collaborative work with external partners and family members regarding the discharge of people who used the service.

Learning, continuous improvement and innovation

Staff were in the process of undertaking HOPEs training to improve their awareness of restrictive practices.

Our findings

Areas for improvement

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with Regulation 9(1) (a) (b) of the Health and Social Care At 2008 (Regulated Activities) Regulations 2014 legal requirements.

- The Trust must ensure there are process to ensure people who use services receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences.
- The service must ensure there are processes to timely update care and risk management plans from the multi-disciplinary team meetings.
- The service must ensure that psychological assessments are completed for people who use services to ensure future planning and longer-term aspirations are identified for each person.

We told the service that it must take action to bring services into line with Regulation 10(1) (2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 legal requirements.

- The Trust must protect people's dignity and privacy when all internal staff can access the clinic room during periods when CCTV observations of people were taking place.
- People who use services must be offered appropriate support to maintain their autonomy and independence in line with their individual needs and stated preferences.

We told the service that it must take action to bring services into line with Regulation 12 (1) (2) (b) (c) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 legal requirements.

- The Trust must ensure they have process to review and monitor the administration of covert medicines. Staff must be suitably trained and competent and this should be kept under review.
- The service must oversee people who use services' concordance with missed medicines or late doses.
- Staff must be trained to evaluate the effectiveness of as required medicines administered.
- The service must have process regarding the ordering of medicines to ensure there is sufficient stock to meet the needs of people who use services.

We told the service that it must take action to bring services into line with Regulation 15(1) (2) of the Health and Social Care Act 2006 (Regulated Activities) Regulations 2014 legal requirements.

- The Trust must ensure that all premises and equipment used by people who use services must be clean, secure, and suitable for the purpose of which they are being used.

We told the service that it must take action to bring services into line with Regulation 17(1) (2) (a) (g) (f) of the Health and Social Care Act 2006 (Regulated Activities) Regulations 2014 legal requirements.

Our findings

- The Trust must ensure there are processes and established systems to record the use of reduce restrictive practices across the service.
- The service must review audits to ensure they are analysed, monitored, and reviewed for themes and trends to support the quality of the service provided.
- The Trust must ensure that the use of restrictive practices is in the best interest of people who use services.

Action the service SHOULD take to improve:

- The Trust should ensure that the Controlled drugs cabinet meets the Misuse of Drugs (Safe Custody) Regulations and be bolted to a solid wall.
- The service should ensure that people using service have privacy when using the family room.

Our inspection team

We carried out a focused inspection of the service. To fully understand the experience of people who use services, we asked the following three questions:

- Is it safe?
- Is it caring?
- Is it well-led?

Before the unannounced inspection visit, we reviewed information that we held about the location. During the inspection visit the inspection team followed the enhanced methodology process by:

- Observing the interactions between staff and patients.
- Spoke with 3 family members.
- Spoke with 16 staff members including the ward manager, matron, registered nurses, the consultant, pharmacists, health care assistants and occupational therapist.
- We reviewed 4 care and treatment records.
- While having a tour of the service we checked the safety and cleanliness of the location and reviewed the clinic room.
- Checked 6 prescription charts and how staff stored and managed medicines.
- Attended a handover.
- Read multi-disciplinary meetings minutes and other documents relating to the service.

What people who use the service say

We spoke with 3 family members who told us most staff were nice and helpful. All said staff were supportive and easy to talk to.

While all said they were happy with the care provided, two said they did not wish to make a complaint and “rock the boat.”

Two of the 3 people we spoke with said that communication regarding incidents could be improved and they often had to chase up for information.

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation