

Good 

Nottinghamshire Healthcare NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

Highbury Hospital
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Nottingham
NG6 9DR
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RHANM	Highbury Hospital	Orion Unit	NG6 9DR

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare NHS Foundation Trust at the Orion Unit. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Nottinghamshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Foundation Trust.

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We only looked at parts of the four key lines of enquiry at this inspection that related to the concerns raised. These were in safe, effective, caring and well led.

We did not rate the service at this inspection as we only inspected one ward and looked at specific issues relating to the concerns we had received.

We found:

- Care records contained up to date and detailed information about patients. Risk assessments and management plans were thorough. Care plans and activity timetables were personalised and indicated that staff understood patients' needs.
- There were regular and effective multi-disciplinary meetings. The team had effective working relationships with other professionals. These relationships enabled access to care for patients who required hospital treatment or other physical health care off the ward
- We observed staff to be kind in their interactions with patients and responded to patients appropriately. Staff protected patients' privacy and dignity and demonstrated that they understood each patient's individual needs, preferences and preferred communication methods.
- Staff on the ward had made changes to improve communication with carers. Carers now had opportunities to talk to staff and discuss the care of their family member or discuss concerns.

- Managers had identified risks that related to the ward and these risks matched staff concerns The ward had had a robust action plan to reduce risks and updated these plans regularly.
- Staff reported and learnt from incidents, complaints and feedback. Nurses had been trained in offering debriefs so that they could support staff when incidents occurred on the ward.

However:

- Staff did not monitor when patients were due for an annual physical health screen which meant that patients could miss annual health screening opportunities.
- When staff carried out physical health observations and there was increased physical health risks identified, they did not always complete and record increased observations; neither did they record a rationale for not completing these.
- Certificates to authorise treatment were not attached to medicine cards. This meant that staff could not be sure that they had the legal authority to administer medication.
- Staff indicated that morale was low and had been affected by both a high level of assaults upon staff and increased scrutiny following a serious untoward incident. Not all staff felt consistently supported and some staff had not received supervision or found it hard to find the time to complete training.

Summary of findings

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

Are services safe?

We only looked at parts of the safe question at this inspection that related to the concerns raised.

- Staff completed a comprehensive mandatory training programme and 90% of staff were up to date with this.
- Patients' risk assessments and management plans were comprehensive and up to date. Staff knew and understood specific risk issues relating to patients and staff communicated these within the team.
- The treating consultant based on the ward had asked another independent doctor to review medication even where second opinion approved doctors had already been consulted when family members were concerned about medication prescribed. Doctors discussed medication in detail with carers to help them to understand prescribing rationale and side effects.
- The qualified nursing staff had been trained in offering debriefs to the ward team and the ward manager ensure that these happened regularly to support staff when incidents occurred on the ward.

However:

- Certificates to authorise treatment were not attached to medicines cards. This meant that staff could not be sure that they had the legal authority to administer medication.
- Staff told us that the high use of bank staff on the ward had an impact on staff safety as bank staff were not always keen to become involved in incidents on the ward, the responsibility rested with permanent staff.

Good



Are services effective?

We only looked at parts of the effective question at this inspection that related to the concerns raised.

- Staff completed care plans which were detailed and personalised, and demonstrated that staff understood patients' needs well. Care planning included individualised activity timetables.
- Staff had completed physical health training and were knowledgeable about patients' physical health. Staff supported patients to live healthier lifestyles.

Good



Summary of findings

- There were regular and effective multi-disciplinary meetings, family and the full multidisciplinary team attended these. The format of these meetings had recently changed as the team wanted to make them more inclusive of family and all professional disciplines in the team.
- The ward had effective working relationships with other professionals both internal and external to the trust. We saw evidence that these relationships benefited patients and that these relationships facilitated accessible care for patients who required hospital treatment or other physical health care off the ward.

However:

- Staff did not monitor when patients were due for an annual physical health screen which meant that patients could miss annual health screening opportunities including screening for metabolic risk.
- Staff told us that accessing supervision and training was sometimes difficult due to pressures on the ward. Two staff told us that they had not received regular supervision in line with trust policy.
- Where the observation of physical health was a trigger to increased risk of behaviours that challenge from patients staff did not always record their rationale for not completing physical health monitoring.

Are services caring?

We only looked at parts of the effective question at this inspection that related to the concerns raised.

- We observed staff to be responsive and kind in their interactions with patients. Staff were skilled and worked in such a way that protected patients' privacy and dignity.
- Staff demonstrated that they understood patients' preferences and their preferred communication methods.
- Staff on the ward had made changes to improve communication with carers who now had opportunities to talk to staff and could access one to one appointments to ask questions or talk about concerns if they wished

Good



Are services responsive to people's needs?

We did not look at the responsive question at this inspection.

Good



Summary of findings

Are services well-led?

We only looked at parts of the well-led question at this inspection that related to the concerns raised.

- Managers had identified risks that related to the ward and these risks matched staff concerns. The ward had had a robust action plan to reduce risks and managers updated these plans regularly.
- Staff reported incidents and learnt from incidents and from complaints and feedback from patients and carers. We saw several examples that this that had taken place.
- The team were supportive of each other and worked flexibly to support the requirements of the ward.

However:

- Staff indicated that morale had been affected by frequent assaults upon staff. Some staff said they did not consistently feel well supported in relation to incidents that had taken place on the ward.

Good



Summary of findings

Information about the service

The Orion Unit is part of Nottinghamshire Healthcare NHS foundation trust and is an eight-bedded mixed gender inpatient unit providing assessment and treatment for patients with learning disabilities, behaviours that challenge and mental health issues. The unit provided accommodation for adults over the age of 18 who are treated informally or under the Mental Health Act.

At the time of our inspection, only four male patients were admitted to the ward. Two of these patients were being nursed in long-term segregation. Long term segregation refers to a situation where in order to reduce sustained harm of others a multidisciplinary decision is made to restrict the patients from mixing freely on the ward. The unit had been closed to new admissions since

19 September 2017 due to staffing levels and the complex needs and challenging behaviour of patients. This had been reviewed two weeks ago; staff numbers had been increased and bed numbers reduced. At the time of our inspection, all four patients were detained under the Mental Health Act.

We undertook an inspection of the core service which included the Orion Unit in November 2017 and rated the service as good in safe, effective, caring, responsive and well led.

We also undertook a Mental Health Act review visit in October 2017.

Our inspection team

The team comprised of two mental health hospital inspectors, an acute hospital inspector and a specialist advisor who was a learning disabilities nurse.

Why we carried out this inspection

We carried out this unannounced inspection in response to the notification of a serious untoward incident that took place. We focused our inspection on the Orion Unit as the concerns related to this ward alone. The concerns were in relation to the care and treatment of patients.

How we carried out this inspection

This inspection was unannounced; we have not rated the hospital. We looked at some areas within four of the domains where concerns had been raised and asked:

Is it safe?

Is it effective?

Is it caring?

Is it well-led?

Before our inspection visit, we reviewed information about the service. We also gathered feedback from a range of stakeholders including commissioners and family.

During the inspection visit the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the ward manager and team leader

Summary of findings

- spoke with nine members of staff including nurses, doctors, health care assistants and an activity worker
- prior to our inspection we spoke to four carers of patients on the ward
- reviewed recent incidents
- observed a handover
- looked at medication records and care records for all four patients on the ward
- looked at specific policies and procedures about the ward.

What people who use the provider's services say

The people who used the service were unable to tell us their experience at the time of our inspection. We tried to speak to a one patient but they were unable to communicate with us.

We spoke to four carers in the month before the inspection. One carer was happy with the care that their family member received and had no complaints.

Three of the carers were unhappy about elements of care on the ward. The carers gave different reasons for this;

however, there were some common concerns. These common concerns related to levels of activity for patients on the ward, standards of care, inconsistent staffing due to bank staff, as well as care for physical health problems. The carers said that they did not think communication between them and staff was always effective and they did not think communication about care within the team was good.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff follow guidance for increasing the frequency of physical observations as described in the National Early Warning Scores and record that this has been completed or a rationale for not completing this.
- The provider should ensure staff monitor when patients are due for an annual physical health review.
- The provider should ensure that certificates to authorise treatment under the Mental Health Act are attached to medicine cards, so the legal authority to administer medication is clear and accessible for staff.
- The provider should ensure that staff are supported appropriately, supervised in line with trust policy and can access training specific to their role.

Nottinghamshire Healthcare NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Name of service (e.g. ward/unit/team)

Orion Unit

Name of CQC registered location

Highbury Hospital

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

We did not look at all aspects of the safe domain at this inspection.

Safe staffing

- The establishment level for qualified nurses was 15.7 whole time equivalent and for unqualified staff was 27.2 whole time equivalent. There were 2.3 whole time equivalent qualified nurse vacancies and 4.7 whole time equivalent unqualified vacancies at the time of our inspection; there was an open ongoing recruitment programme for these posts.
- In the months of May and June 2018 there were 891 shifts required to be filled with bank and agency staff, of these there were 17 shifts that had not been filled by bank and agency staff. This meant only 1.9% were unfilled.
- Out of the 891 shifts that were filled with non-permanent staff, only three of these shifts were filled by agency the rest were filled by bank staff. Bank staff are working directly for the trust and generally have a better level of knowledge and familiarity with the trust's procedures compared to agency staff and so provided a greater continuity of care.
- The average rate of staff sickness in the last three months had reduced from 12.9% from our last inspection in November 2017 to 10%. At the time of our inspection, there was a staff member on long-term sick due to an incident of assault that had taken place on the ward.
- The average rate of staff turnover in the last three months was 16.3%. Some staff had gone on to new roles. Staff told us the role could be stressful due to the level of patient assaults on staff. There had been an increased level of scrutiny on the ward due to a serious untoward incident that had taken place earlier in the year and the stress relating to the ongoing management of patients with high clinical needs. Parents and carers had raised concerns about care and treatment. The ward manager said this might have had an impact on staff turnover.
- At the time of our inspection, there were patients who required high level of observations due to their complex needs. The ward therefore required a higher staffing ratio and employed bank staff and very occasionally agency staff to complement their regular staff team and to ensure safe staffing levels. Bank staff used were normally familiar with the unit or were permanent staff who chose to work extra shifts.
- The staff rota was planned six weeks in advance and the unit tried to balance bank and permanent staff throughout the days. However, we were told staff occasionally swapped shifts at weekends, leaving more shifts to be filled by bank staff.
- The ward manager told us that bank staff took their breaks during a shift but that this was not always possible for permanent staff due to clinical need on the ward. Staff told us that bank staff were not always willing to become as involved in restraint or responding to an incident when a patient presented with challenging behaviour. One member of staff felt this placed permanent members of staff at increased risk.
- The trust and managers had reassessed the number of staff required for the ward. There had been a recent programme of recruitment and the ward had recruited a clinical specialist nurse, two senior nurses and three more health care assistants to improve staffing on the ward.
- On the day of our inspection, the permanent staff included two qualified nurses, three unqualified staff and two team leaders were on shift. In addition, there were four unqualified bank staff. This matched the staff required for the shift. The team leaders spent half of their time on the ward and the other half was spent carrying out non clinical duties
- All bank and agency staff that worked on the ward completed an induction. The trust had recently introduced a comprehensive induction for bank and agency staff.
- We observed that there were qualified nurses on the ward in patient areas at the time of our inspection.

Are services safe?

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

- Staff told us there was normally enough time for patients to have regular one to one time with their named nurse. However, one member of staff said this did not always happen.
- Activities and escorted leave were rarely cancelled due to staffing.
- There were enough staff to carry out physical interventions and observations. All staff, including bank staff completed management of violence and aggression training and the trust provided annual updates.
- There was sufficient medical cover on the ward. Two consultant psychiatrists and two junior doctors worked on the ward and there was medical cover between 9am and 5pm. There was an on call system when the doctors were not available; on call doctors were able to access all relevant patient information and responded in a timely way
- Mandatory training figures indicated that 90% of staff were up to date with their mandatory training. There was one area where compliance was low at 67% and this was for training in care programme approach. Mandatory training was comprehensive and included safeguarding adults and children, lifesaving and suicide awareness. The trust had made sepsis a part of mandatory training and this was contained in the trust induction programme.

Assessing and managing risk to patients and staff

- During the six weeks prior to our inspection there were 21 episodes of restraint and four of these were in prone position. During this period, there were 58 episodes of violence and 56 of these were towards staff. One of the reasons staff had used restraint was to reduce a patients' risk of self-harm.
- Staff completed a risk assessment of every patient on admission. All patients had up to date, detailed risk assessments that clearly outlined risks and suitable risk management plans. Staff updated risk assessments regularly and when incidents occurred. Staff also completed a separate physical health risk assessment. Staff knew specific risk issues relating to patients. Staff recorded information about risk and incidents effectively in patients' care records and we observed that these were discussed in a lunchtime nursing handover. When we spoke to staff, they demonstrated that they understood the risks associated with individual patients. There were regular reviews to discuss risk and when we looked at care records, we saw that staff considered how they could manage risk differently if a particular approach was not working.
- We did not see evidence of blanket restrictions on the ward. Staff assessed restrictions for patients individually. For example, there was flexibility about visiting times depending on the patient and their visitor's availability.
- The trust had an up to date policy for the observation of patients. This detailed the levels of observation needed to keep patients who were a risk to themselves or others safe. Staff were aware of what level of observations individual patients needed and this information was passed over to the next shift during handover.
- Staff completed observations in line with policy. Senior ward staff reviewed observation duties for staff so that they did not carry out observation for an extended period.
- Staff used restraint as a last resort if de-escalation did not work. There were detailed positive behaviour support plans in patients' care records that demonstrated patient involvement and they clearly described strategies staff could use to prevent triggers or respond to early warning signs. The plans also included reactive strategies if other approaches had failed. Incident reports demonstrated that staff attempted to de-escalate before using restraint.
- Staff were trained in safeguarding, there had been one safeguarding alert raised since January. The trust had recently audited safeguarding and found that staff were knowledgeable and understood safeguarding processes. Staff knew how to prevent patients from abuse or harm.
- We reviewed patients' medicine cards. We saw that doctors had appropriately requested second opinion appointed doctors (SOADS) to review medication. Where medication was above limits advised in British National formulary (BNF) this had been agreed by the SOAD and was regularly reviewed in multidisciplinary team meetings which included carers. We also saw occasions where doctors had sought further medical opinion from an independent doctor outside of the trust when family

Are services safe?

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

had identified concerns about medication. Doctors completed quarterly audits of medication to ensure that their prescribing was in line with a national project STOMP (Stop over medicating people with learning disabilities).

- When we reviewed medication cards, we did not find that the current certificates to authorise the medication were attached to the medicines card. They were available but not stored with the medicines cards. This meant that staff could not be sure whether they had been lawfully administering patient's medication.
- We saw evidence in care records that doctors recorded in detail the conversations that they had with carers about a patient's medication and explained the side effects of medication and reasons for prescribing.
- Children did not usually visit ward; this was because they could be at risk from patients. Patients could meet with children if assessed as safe off the ward. However, staff gave us an example of how they had worked flexibly with a patient who could not leave the ward. A seventeen-year-old family member had met with a patient on the ward; the team had assessed this as being in the best interests of the both the patient and family member.

Track record on safety

- There had been one serious untoward incident on the ward in the last six months.
- The serious incident concerned a patient who had developed a serious infection on the ward. The patient became ill and was admitted to an acute hospital to be cared for. The patient's health and wellbeing had been at significant risk. The trust had investigated this and made series of recommendations and a quality improvement plan.
- We looked specifically at the recommendations contained in the action plan and we were assured that the ward had already made several changes in response and this was within the timeframe set. For example, the ward was working with the trust's physical health care staff to organise a comprehensive programme of physical health training for staff, including sepsis, aseptic non touch technique, tissue viability and

physical health monitoring. Staff told us overall their confidence had increased because of the training. However, one member of staff said generally staff still had training needs in respect of tissue viability.

Reporting incidents and learning from when things go wrong

- Staff reported incidents and we saw evidence that this took place. On the day of our inspection, two staff had been assaulted and had their clothing ripped by a patient. We saw that staff had reported this incident in a timely way. These staff stayed on the ward to work after the assault took place.
- We reviewed incidents and saw that a range of incidents were reported, the most frequently reported incident was violence and aggression to staff.
- Staff spoke with carers when incidents occurred and were open and honest. We saw evidence that this had happened in relation to the serious untoward incident that had taken place earlier in the year.
- Staff received feedback from incidents both inside and outside of their service.
- Staff discussed learning from incidents at handovers, team and multidisciplinary meetings, ward reflective practice sessions and supervision. Ward managers attended a managers' meeting where learning from incidents was shared across services. Changes were made following feedback from incidents. We saw examples of this. For example, the trust had approved changes to the ward environment to improve the acoustics on the ward – the acoustics meant that the ward would be a noisy place and this was not ideal for patients, particularly patients with a diagnosis of autism.
- Staff said that debriefs had improved and told us that debriefs now took place more frequently usually after handover. Although one member of staff said that they had not received a debrief following being assaulted by a patient in recent weeks. All qualified band six nurses across the directorate had, or were completing debrief training so that they could support debriefs both in their service and externally. Staff were working together to improve debriefing in response to patient on staff assaults.

Are services effective?

Good 

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

Our findings

We did not look at all aspects of the effective domain at this inspection.

Assessment of needs and planning of care

- Staff completed comprehensive mental health assessments of patients at admission and these were detailed.
- Care records showed that staff undertook a physical examination of each patient on admission and continued to monitor the patients' physical health. There was a new patient on the ward at the time of our inspection; we saw staff had carried out a physical examination and that this was comprehensive. Staff completed a body map at initial assessment and updated these daily.
- Staff monitored patients' physical health weekly. Staff attempted to complete physical observations four times a day; they recorded physical observations using the National Early Warning Score. Staff escalated concerns to doctors. However we observed on two occasions where scores indicated that there might be a concern and that observations should be increased, this was not always completed. We saw that staff had not always recorded hourly observations when scores indicated increased risk. Staff did not record a rationale for not completing these.
- Doctors accessed the electronic system for blood test results. Effective handovers took place where doctors communicated with each other to ensure they followed up outstanding results. Nursing staff were able to telephone for blood test results and the ward were reviewing increasing access to the electronic system for nursing staff.
- Care plans were up to date, personalised, holistic and recovery orientated. Care records demonstrated that staff had involved patients in care planning. The multidisciplinary team reviewed care plans during reviews with professionals, carers and patients. These reflected the needs of patients that had been identified in initial assessments and community treatment reviews.

- Care plans demonstrated staff had a good understanding of patients' needs. There was a structured activity timetable alongside care plans. These took into account patients' individual needs. The care plans were detailed as to how and when staff should engage with patients in their activities. In the four weeks before our inspection, 200 hours of activity had taken place on the ward and there were two activity workers to support this.
- Information needed to deliver care, including in the electronic care records, was stored securely and was available to all staff including bank staff.

Best practice in treatment and care

- Staff reviewed the effects of medication on patients' physical health and followed trust policy, ensuring that when patients were prescribed a high dose of antipsychotics they had an electrocardiogram and blood tests were completed. Staff used appropriate communication tools including the Disability Distress assessment Tool (DISDAT) to understand patients' pain levels. Staff monitored bowel movements of patients when required. Patients had access to dentistry and podiatry. A podiatrist was on the ward on the day of our inspection.
- Staff had access to a range of physical health training including courses about epilepsy and diabetes. Staff were knowledgeable about patient's physical health on the ward. Staff also ensured that patients received the right care from different healthcare professionals to meet their needs.
- We reviewed all patients' care records and saw that patients had good access to physical health care including specialist health care professionals. We saw varied examples of this and staff worked hard with patients to prepare them to receive appropriate care for problems that might have been distressing for them. Staff supported patients to live healthier lives for example in relation to nutrition and physical activity but also ensured that patients had choice. However, staff did not monitor whether an annual physical health screen had taken place and this meant patients might miss annual screening opportunities for metabolic risk.

Are services effective?

Good 

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

- Staff monitored patients' hydration and nutrition levels appropriately. When staff nursed patients in seclusion staff used the malnutrition universal screening tool (MUST.)

Skilled staff to deliver care

- The full range of mental health disciplines and workers provided input to the ward. This included psychiatrists, occupational therapists (OT), activity workers, speech and language (SLT) therapists and a psychologist. The ward had increased both OT and SLT staffing to ensure there was sufficient support for patients.
- The trust provided an induction for permanent staff and bank staff. The trust had introduced a full induction programme for bank staff six weeks ago. This included a comprehensive checklist so that ward managers were assured that bank staff were knowledgeable and confident to work on the ward.
- Staff had access to team meetings appraisals and supervision. Team meetings took place fortnightly and staff recorded minutes. These meetings included relevant information for staff including patient risk, learning and actions following incidents and complaints. Staff received supervision although two members of staff said their supervision was very infrequent and trust data indicated that supervision had just fallen below the trust target of 80%. Overall 77% of staff had received supervision in line with trust policy. At the time of our inspection, 86% of staff had received an appraisal. The ward manager was keen to improve these figures, but clinical needs on the ward had meant sometimes that supervision and appraisals were cancelled.
- In addition to supervision, the ward psychologist provided reflective practice sessions and content and learning was shared with staff that were unable to attend.
- Staff had completed an e-learning course in autism, 93% of staff had completed this. The ward manager had attended three-day training in autism. Most of the staff had completed one-day training course in positive behaviour support (PBS) and those who had not, had the opportunity to attend further training days. There were plans for four unqualified staff to attend advanced

training in PBS over the next two years. The ward psychologist had recently offered training to help staff to understand and communicate using Makaton. Makaton uses signs and symbols to help people communicate.

- The manager wanted to identify further in depth training specific to the patients on the ward to improve staff knowledge. Three staff had applied to attend a trust event about the specific needs of patients with learning disabilities and autism later in the year. We spoke with unqualified staff who had been given access to phlebotomy training.
- However, staff told us that accessing training could be difficult due to the staffing level required on the ward and that they were not always able to access the training that they requested

Multi-disciplinary and inter-agency team work

- Staff from the ward had recently visited an assessment and treatment unit for people with learning disabilities that had received a rating of outstanding from the CQC. Because of this visit, the ward had changed the way they conducted multidisciplinary reviews of patient care, to ensure carers and all multidisciplinary staff had a good level of input into reviews.
- There were regular and effective multidisciplinary meetings. Meetings took place fortnightly for each patient. We reviewed care records and saw that carers attended, were involved in decisions and consulted at about their family member's care. Staff from all professional disciplines within the team attended including pharmacists.
- Three nursing handovers took place daily. On two days of the week, these were extended to the whole of the multidisciplinary team. We observed part of an effective handover in the middle of the day. We saw a thorough handover where staff discussed patients including; medication, physical health activity and risks. Both qualified and unqualified staff took an active role in contributing to the discussion.
- There were effective working relationships with other professionals from both internal and external to the trust. The ward had improved communication with professionals and ensured that they were invited to multidisciplinary reviews. The ward manager was meeting face to face with commissioners on a monthly

Are services effective?

Good 

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

basis to support patients to discharge. The ward had developed a good working relationship with a dental service and had recently successfully supported a patient to have an endoscopy.

- The ward had good relationships with acute liaison nurses who worked with acute health care colleagues to provide accessible care for patients who required hospital treatment or other physical health care off the

ward. The ward worked with the intensive community assessment treatment team (ICATT) team. Following a recent serious untoward incident, the team had developed an improved relationship with the surgical team at the local hospital and knew whom to contact if they required support. A specific pathway was in place for a patient in the case of any required surgical intervention.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed that staff were respectful and responsive to patients. We saw staff working with patients who demonstrated challenging behaviour. Staff demonstrated that they were skilled, kind and protected patients' privacy and dignity.
- Staff demonstrated that they understood the needs of their patients and their personal likes and dislikes. Staff talked about changes in patients' body language and the different sounds they made as early warning signs that they were content or agitated. We observed one staff working closely with a new patient to identify their interests and staff descriptions of patients and their care was in line with what was documented in care records. Staff understood the individual communication needs of their patients and used easy read, pictorial symbols and signing to communicate with patients to understand them.

The involvement of people in the care that they receive

- The ward had made changes to improve communication with carers. Staff said this was helpful for carers who had expressed concerns about the care of

a patient. Carers could attend an appointment with a senior member of ward staff once a fortnight where staff listened and offered carers support. Two carers had engaged in this. Staff updated carers through weekly phone updates. We reviewed care records and saw that staff had recorded conversations with parents about the care of patients including those that took place in multidisciplinary review meetings. We spoke to local advocacy services who told us communication between the ward and carers had improved.

- Carers could feedback about their experiences through a comments box in the reception area. There was also an opportunity to complete service user and carer experience forms during a patient's stay or at discharge.
- There was information in the reception area about how to contact the Patient Advice and Liaison Service and make a complaint.
- The ward manager was working with the patient experience team to develop training for staff to improve working with carers. Some staff had already completed training in how to work better with carers. There were regular patient meetings, where patients could give feedback on the service. We saw that staff used different methods to enhance communication with patients at these meetings.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

Not inspected

The facilities promote recovery, comfort, dignity and confidentiality

Not inspected

Meeting the needs of all people who use the service

Not inspected

Listening to and learning from concerns and complaints

Not inspected

Are services well-led?

Good 

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

Our findings

We did not look at all aspects of the well-led domain at this inspection.

Good governance

- Staff received mandatory training and there were systems in place to monitor this. In addition to this staff had been offered the opportunity to access relevant additional training, Staff told us that pressure on the ward sometimes hindered attending training.
- The trust had responded to the changing needs of patients admitted to the ward and the impact of delayed transfers of care, which were often caused by a lack of suitable placements or 'bespoke' packages. The ward had reopened to admissions two weeks ago; it had been closed to admissions since 19 September 2017. Admissions now took place between 9am and 5pm when there was a higher level of staff available and the admission process had been amended. The ward had improved their escalation process for delayed discharges within the trust and with relevant external bodies. The trust had reviewed their staffing. In response to this, the ward had increased staffing numbers and reduced the ward numbers.
- Audits of prescribed medicines and of safeguarding processes had taken place on the ward, however staff had not audited physical health observations to check that these had been completed and acted upon correctly.
- Staff reported incidents and learned from incidents, complaints and feedback from patients and carers. There had been learning and changes made following a recent serious untoward incident and the trust was also reviewing the wording in a policy following a complaint from a family.

- The ward also took an active role to learn from a national project; the Learning Disabilities Mortality review, they had identified the top three priorities from this as part of staff training and key areas of monitoring in physical health.
- The trust used key performance standards to gauge the performance of the team. The ward manager was aware of the standards and the performance of the staff team. There was a data collection and monitoring process for ensuring that staff used the least restrictive approach with patients.
- The ward could refer items to the risk register and these items matched staff concerns. The significant risks were delayed discharges, staff turnover and an increased level of clinical need for individual patients that were not suitably placed. The ward had been proactive and doing all it could to meet the needs of patients that required a more suitable placement to appropriately meet their needs. There were comprehensive action plans and dated completed actions in relation to the items that staff had submitted

Leadership, morale and staff engagement

- Staff indicated that their morale had been affected by frequent assaults from patients and that they did not feel well supported when this happened. Some staff felt that bank staff were less willing to intervene when there were patient on staff assaults and that permanent staff were more likely to be affected when this took place. Staff also told us that they felt that they had faced a great deal of scrutiny in the last few months and that this had negatively affected them. The ward manager told us that there was support for staff from the trust occupational health and physiotherapy team, as well as the employee counselling service.
- The team were supportive of each other and the team manager spoke highly of staff flexibility and support that they offered when extra staff were required. Staff told us that they received support from other team members. The team had a 'wellness champion', a member of staff who led on staff wellbeing.