Cygnet Thors Park

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This service was placed in special measures in April 2019. Insufficient improvements have been made such that there remains a rating of inadequate for any core service, key question or overall. Therefore, we are taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Edward Baker
Chief Inspector of Hospitals

Overall summary

We rated Cygnet Thors park as inadequate because:

- The service did not provide safe care. Staff were unable to call for help when they or a patient needed protection from violence or aggression. Staff personal alarms did not work when we tested them and the display panel which helped staff to find the emergency, displayed an inaccurate location.
- The provider had not identified or sufficiently mitigated blind spots in the ward environment. This meant that staff and patients were unable to observe all parts of the ward to ensure their safety.
- Managers failed to ensure there were enough staff on duty to provide the required levels of patient observations in a safe way. Staff were completing patient high level observations from two to 12 hours continuously (on rotation) without a change of activity or alternative task. The provider did have a protocol in place which stated that staff should not undertake close observations for longer than two hours without a break but this protocol was not adhered to during the inspection. The records for the patient's care plan, their daily risk assessment, and their observation plans did not always match.
- Managers failed to complete bi weekly CCTV reviews for three weeks during September 2019. The CCTV was not working effectively during this time and was not identified by the provider. This was an action from the November 2018 inspection. We found the closed-circuit television (CCTV) system was not working and the manager was not aware of this until the inspection.
- Staff did not plan sufficiently for patient discharge. Patients stayed at the service for longer than they needed to with the average stay being 1423 days. One transition plan for a patient's discharge had action points which staff had not completed and it was not clear why their discharge was delayed.
- The registered manager did not have enough oversight of all the safety concerns and risks at the service and had not acted to correct all the concerns raised at previous inspections or from enforcement action.

However;

- The ward environments were clean. Staff assessed patient risks regularly, managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs

Summary of findings

of the patients cared for in a ward for people with a learning disability and autism and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	Brightlingsea Ward Thorrington Ward

Summary of findings

Contents

Inadequate

Cygnet Thors Park

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to Cygnet Thors Park

Cygnet (OE) Limited is the registered provider for Cygnet Thors Park, based in Thorrington, North East Essex. Cygnet Thors Park provides support and treatment for up to 14 men with learning disabilities and complex needs. The provider accepts patients who have additional mental and physical health needs, and those who have been detained under the Mental Health Act. At the time of the inspection, there were eight men receiving care and treatment at the hospital. The service comprises three elements:

- Thorrington Ward is an eight bed service that provides assessment and intervention for men with learning disabilities, complex needs and behaviours.
- Brightlingsea ward is a four bed service for individuals who require support that is more intensive. There are four self-contained, bespoke apartments.
- There are also two bespoke single person apartments that provide a more independent living environment.

Cygnet Thors Park is registered with CQC to carry out the following regulated activities:

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

The provider had a registered manager and a controlled drugs accountable officer at the time of the inspection.

CQC last inspected Cygnet Thors Park on 5 February 2019 as part of a follow up inspection against a requirement notice which we issued on 15 January 2019. Following the last inspection in February 2019, CQC rated the service overall inadequate and placed it in special measures. We issued a warning notice for the following breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider did not maintain the clinic room, medication or equipment safely.

The provider had not ensured the environment was adequately maintained or decorated.

During the inspection we found the provider had resolved these concerns.

The provider did not ensure staff completed enhanced observations in line with patient care plans and the provider's observation policy.

The provider had not ensured personal alarms and the alarm panels were repaired.

During the inspection we found the provider had not addressed these concerns.

The provider had not ensured staff recorded all physical restraints following incidents.

During the inspection we were unable to determine if the provider had resolved this concern as the CCTV was broken.

- Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider did not ensure all staff had received supervision. This was identified at the inspection in December 2016.

The provider had not ensured that all staff received appraisals. This was identified at the inspection in December 2016.

The provider had not ensured that all staff were up to date with all mandatory training.

During the inspection we found the provider had addressed these concerns.

- Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider had poor oversight of significant issues and adequate action to manage them was not always taken.

During the inspection we found the provider had not addressed this concern.

The provider did not complete adequate investigations following complaints and use all available evidence.

During the inspection we found the provider had addressed this concern.

Summary of this inspection

CQC also issued a requirement notice for the following breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The provider had not maintained the CCTV to ensure accurate timings.

During the inspection we found the provider had not addressed this concern.

- Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not ensure that actions recommended from care and treatment reviews were recorded clearly and were easily accessible.

During the inspection we found the provider had a addressed this concern.

This does not affect our judgement.

Following this inspection; the care quality commission have decided to keep the hospital in special measures. This will be further reviewed in accordance with our methodology. More details can be found in the report.

Our inspection team

The team that inspected the service comprised two CQC inspection managers, two CQC inspectors and a variety of specialists: including an expert by experience and a specialist adviser.

Why we carried out this inspection

We inspected this service to check the provider's compliance against a warning notice we had issued.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- spoke with ten staff including doctors, nurses, support workers, speech and language therapists and psychologists
- spoke with four patients
- spoke with two relatives of patients
- visited all wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients using a Short Observational Framework for Inspection (SOFI).
- spoke with the registered manager
- looked at eight care and treatment records of patients
- carried out a specific check of the medication management and the clinic room
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

During the inspection we spoke with four patients. They told us that staff were kind and genuinely cared about their wellbeing. Staff supported them to make decisions and complete activities.

We also undertook one Short Observational Framework for Inspection (SOFI). which is a tool we use to be able to capture the experiences of people who use services who may not be able to express this for themselves. We observed one patient for 30 minutes and observed 28 interactions between staff and patients. All observations demonstrated positive and supportive interactions between staff and patients. We saw the patient was engaged in meaningful activities and staff were relaxed and knew how to interact with the patient in a positive way.

We spoke with two family members of patients. Both were involved in their relatives care and said staff kept them informed about their family member. Family members said that staff went above and beyond for their relative and were positive about the care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe inadequate because:

- The ward environments were not safe for patients. Managers had not identified or sufficiently mitigated blind spots in corridors. Managers had not assessed this risk as part of their environmental risk assessment and the patients on the ward were at risk of self-harm, suicide, violence and aggression. Following the inspection, the provider showed evidence they had installed one convex mirror to mitigate this. CQC was satisfied with this response.
- Managers failed to ensure they deployed enough staff to complete observations in line with provider policy, to ensure staff had a change of activity when completing observations. Staff were completing patient high level observations from two to 12 hours continuously (on rotation) without a change of activity or alternative task. The provider did have a protocol in place which stated that staff should not undertake close observations for longer than two hours without a break but this protocol was not adhered to during the inspection. This was against the providers observation protocol and National Institute for Health and Care Excellence guidance. Because of this, three staff had been found asleep during their shift and one had left their post feeling unwell between February 2019 and September 2019
- Observation levels on observation plans, daily risk assessments and care plans did not always correspond with each other. Staff did not always ensure the observation timings on patient's observation plans were prescribed in an individualised way. One patient had high level observations prescribed for their safety during the day, which reduced at the onset of the night shift. It was not clear why the risk reduced at this point as the patient was still awake until later in the evening.
- Levels of restrictive interventions were increasing. This service had 30 incidences of restraint (five different service users) between 1 July 2019 and 30 September 2019. This was despite there being three fewer patients since the previous inspection where the number of restraints was 42 within a 12 month period. The provider cited the cause of this was an increase in accuracy of reporting.
- Managers failed to complete bi weekly CCTV reviews for three weeks during September 2019. The CCTV was not working effectively during this time and was not identified by the

Summary of this inspection

provider. This was an action from the November 2018 inspection. The CCTV was not recording. When we requested to view the recordings, staff found that the CCTV had not recorded video for three weeks.

- Staff alarms did not always work when they activated them. We asked five staff to pull their alarms during the inspection. Two alarms did not activate, and the location display panel showed an incorrect location for another alarm.
- We found that information stored on the electronic records system was not always accurate or easy to find. The provider stated that the changeover between paper and electronic systems was due to be completed by 21 October 2019. Whilst managers had taken steps to improve the quality of clinical information by reducing the volume of notes stored in patient folders, staff said they still found it difficult to locate information in patient files.

However:

- The wards were clean well equipped, well-furnished and well maintained.
- Staff assessed patient risks well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (Stop Over-Medicating People with a learning disability).
- Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective good because:

Summary of this inspection

- Staff assessed the physical and mental health of all patients on admission. They developed individualised care plans which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.
- The staff team included a full range of specialists required to meet the needs of patients in the service. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

Good

We rated caring good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- During the inspection we observed 28 positive staff and patient interactions. Staff occupied patients with activities which they enjoyed, and staff knew what their needs were.
- Patients and family members said that staff were kind and caring.

Summary of this inspection

- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff involved family members in their relative's care and treatment.

Are services responsive?

Requires improvement

We rated responsive requires improvement because:

- Staff did not manage the discharge pathway well on patient's behalf. Patients remained in the service on average for 3.8 years. Managers reported the reason for this was a lack of suitable placements. Staff were not always assertive in managing the discharges and keeping records of actions they had taken to follow up placements and prepare the patient for discharge. As a result, patients had excessive lengths of stay and delayed discharge.

However:

- Patients' privacy and dignity were supported by the design, layout, and furnishings of the ward. Each patient had their own bedroom with an en-suite toilet. There were quiet areas for privacy. The food was of good quality.
- Staff supported patients with activities outside the service, such as work, education and family relationships.
- Patients who were disabled or who had communication or other specific needs could be supported by the service.
- If a patient or family member complained or raised a concern the service took them seriously, investigated and learned lessons from the results, and shared these with the whole team and wider service.

Are services well-led?

Inadequate

We rated well-led inadequate because:

- Patients were not kept safe by the governance systems within the service. Further evidence of this can be found in the detailed well led section of the report
- Leaders had not maintained oversight of all significant safety concerns which CQC had raised.
- Staff were undertaking observations for long periods of time without a change of activity, there were unmitigated risks such as blind spots, faulty staff personal alarms and broken CCTV in the ward environment.

Summary of this inspection

- Managers were not aware of these issues until CQC raised them at the inspection. We found blind spots in the ward environment which managers had not identified as part of their risk assessment and there were insufficient staff on the wards to manage them appropriately.
- Leaders failed to put in place adequate measures to ensure compliance with provider policy. Managers did not have an adequate system of accountability to ensure the service operated safely. Managers had developed and implemented clear structures and processes but failed to ensure that staff were following them.

However:

- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.
- The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.
- The service engaged well with patients, staff and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- At the time of the inspection seven patients were receiving treatment under the Mental Health Act.
- Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.
- As of 24 September 2019, 97% of the workforce in this service had received training in the Mental Health Act. The training compliance reported during this inspection was higher than the 67% reported at the last inspection.
- Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.
- The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.
- Patients had easy access to information about independent mental health advocacy who attended the service twice weekly. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time.
- Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.
- Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.
- Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.
  - The service had one informal patient however, this patient was unable to leave the ward in accordance with their Deprivation of Liberty Safeguard.
  - Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. As of 14 October 2019, 93.3% of staff had received training in the Mental Capacity Act. The provider stated that this training is mandatory.
- There was one deprivation of liberty safeguards application in place at the time of the inspection and managers monitored staff, ensuring they did them correctly.
- There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.
- Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff used picture cards and social stories to help patients to understand the decisions they needed to make. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.
- When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff consulted professionals and family members to consider the patient's wishes.
- Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.
- The service completed annual audits to ensure that staff were following policy on the Mental Capacity Act.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Staff completed regular risk assessments of the ward environment but failed to identify the blind spots as a risk. We found blind spots in the corridors of both wards which were not mitigated by convex mirrors or monitoring by closed-circuit television (CCTV). This meant that staff could not observe patients in all parts of the wards. Following the inspection the provider showed evidence they had installed one convex mirror to mitigate this. CQC was satisfied with this response.

Staff alarms did not always work when they were activated. We asked five staff to pull their alarms during the inspection. Two alarms did not activate, and the display panel showed an incorrect location for another alarm.

Managers failed to complete bi weekly CCTV reviews for three weeks during September 2019. The CCTV was not working effectively during this time and was not identified by the provider. This was an action from the November 2018 inspection. The closed-circuit television (CCTV) was not recording. When we requested to view the recordings, staff found that the CCTV had not recorded video for three weeks. Staff had reviewed live footage on a weekly basis rather than reviewing historic recordings. Staff were therefore, unable to use the CCTV to investigate incidents.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up to date and the premises were clean. Staff followed infection control policy, including handwashing.

The wards had a clinic room, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned physical health monitoring equipment.

Safe staffing

Managers failed to ensure they deployed enough staff to complete observations in line with provider policy, to ensure staff had a change of activity when completing observations. Observation allocation records showed Staff were completing patient high level observations from two to 12 hours continuously (on rotation) without a change of activity or alternative task. this was contrary to guidance issued by the National Institute of Health and Care Excellence (NICE) and to the provider's high level engagement and observation and continuous observation protocols. These documents state that a staff member cannot undergo close observations for longer than two hours without a change of activity. Between February 2019 and September 2019, three staff had been dismissed for sleeping on shift and one staff member had left their post for 80 minutes feeling unwell. They were not replaced in this time. We were concerned that staff were carrying out observations longer than what the hospital policy stipulates. The lack of observations or length of time staff carried out observations could have potentially impacted on patient safety.

The service reported that the number of vacancies for all staff was 22 (32%), of which, 19 were support workers and three nurses. This was lower than the rate reported at the last inspection on 1 July 2017 and 1 November 2018.

The service restricted the use of agency nurses by booking bank staff and offering regular staff extra hours and encouraged bank and agency nurses to take substantive posts where possible.

Managers requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates. The service had 59.9% staff leavers between 1 February 2019 and 24 September 2019. This was not comparable to the previous inspection data as it was not reported. Managers had dismissed twelve staff for not meeting the provider's expectations which had increased the turnover levels.

Managers supported staff who needed time off for ill health, managers had worked to address problems with staff sickness and levels of sickness were low. The sickness rate for this service was 5.2% between 1 February 2019 and 30 September 2019. This was lower than the sickness rate of 8.3% reported at the last inspection.

Managers had not correctly deployed staff for each shift to complete observations as prescribed. Shifts were staffed by two staff for each patient (16 staff), however, this did not allow for additional staff on each shift to support each other and patients during an emergency, or to support leave and meal times. We found five shifts out of 11 where there were 16 staff or less on the ward.

Managers had not considered the levels of staffing required to carry out enhanced observations of patients. As a result, we found 50 occasions in 11 shifts where staff had completed more than two hours of observations and 59 more occasions where they had completed more than four hours and up to 12 hours of continuous observations without a change of activity.

Additionally, we found five occasions where staff had been allocated to cover additional duties whilst covering high level observations with a patient. This meant the service did not have enough staff on each shift to carry out any physical interventions safely. We highlighted this at our inspection in 2018.

Patients had regular one to one sessions with their named nurse and also had key support workers who they could approach for additional support.

Patients rarely had their escorted leave, or activities cancelled, even when the service was short staffed. However, due to some patients being on fluctuating levels of observations, there was a need to ensure there were adequate staff to meet this requirement. Therefore, there was a risk that leave could cause staffing levels on the ward to be lower than usual and could leave staff on the ward less able to respond in an emergency.

Staff shared key information to keep patients safe when handing over their care to others in daily handovers.

The service had enough daytime and night time medical cover and a doctor available to go to see patients in an emergency.

Staff had completed and kept up to date with their mandatory training. The compliance for mandatory and statutory training courses on 24 September 2019 was 93%. Of the training courses listed none failed to score above 75%, this was higher than the rates reported at the previous inspection where eight topics failed to score above 75%. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff completed a risk assessment for each patient when they were admitted and reviewed this monthly and after any incident. We reviewed eight patient records and found that staff had completed and updated the risk assessment for all of them. Staff used a standard risk assessment tool set out by the provider.

Staff knew about risks for each patient and acted to prevent or reduce risks. Each patient had a positive behaviour support plan which helped staff to identify when to act and what support patients required.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff reassessed patient risk daily on the electronic notes recording system. Key information was also displayed on a whiteboard in the nurses' office so that all staff could see how each patient was. However, we found staff did not always update observation levels attached to the daily risk assessments on the electronic

system. On the date of the inspection, the notes for five patients contained behaviour which showed increase or reduction of risk, however staff had not changed the patients' observation levels or recorded a reason for maintaining them.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Levels of restrictive interventions were increasing. This service had 30 incidences of restraint (five different service users), between 1 July 2019 and 30 September 2019. This was higher than the previous inspection where the number of restraints was 42 within a 12 month period. The provider did not report any incidences of prone restraint.

Staff participated in the provider's restrictive interventions reduction programme and attempted to de-escalate patient's behaviour before they required intervention. They did this using responses and activities identified in the patient's Positive Behaviour Support plan.

Of the 30 reported restraints, staff had instigated 13 because of an aggressive threat and six resulted in an injury. Data did not clearly identify whether staff or patients were injured.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff did not place patients in seclusion or long-term segregation and did not use rapid tranquillisation.

Staff had undertaken a project to reduce risk presented by self-harm by training staff and gathering data from patient incidents. This work was currently on-going, so the provider did not have any data to support the success of the project.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training, at the time of the inspection 95% of staff had received training in levels one to three, adult and child safeguarding. This was higher than the previous inspection where compliance was 75%. Two staff had received training in levels four and five.

Staff could give clear examples of how to protect patients from harassment and discrimination. Staff knew how to recognise adults and children at risk of or suffering from harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns, the service had a safeguarding lead. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This service made 24 safeguarding referrals between January 2019 and September 2019. The number of safeguarding referrals reported during this inspection was higher than the 17 reported at the last inspection. Senior staff kept a record of all outstanding safeguarding investigations and the actions associated with them.

Staff access to essential information

At the time of the inspection the service used a combination of electronic and paper records, we found records lacked accuracy and detail. The provider stated this was due to the transition between paper and electronic records, due to complete 21 October 2019. Staff completed daily notes and risk assessments on the provider's electronic system and kept other notes such as care plans and risk assessments on paper. However, we found five of these risk assessments did not have accurate severity ratings. The provider was in the process of transferring to a fully electronic system.

Inadequate

Wards for people with learning disabilities or autism

During the inspection we found five observation plans and care plans where the prescription for the patient's observations did not match, and five daily risk assessments where the observation levels did not match what the doctor had prescribed. One observation care plan stated that the patient's observation levels should decrease at night but did not specify what time this meant. Staff said this applied to the time that the shift changed, however there was no record that the patient's needs reduced specifically at this time in the early evening.

The provider was working on improving the quality of the paper notes and had reduced the amount of information in the files. However, there was still room for improvement. Three staff we spoke with said they found it difficult to find the information they needed due to the volume of the patient files.

Staff stored records securely in a secure cabinet or on a password protected computer system.

Medicines management

Staff followed systems and processes when prescribing, administering, recording and storing medicines.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff used the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) and the Glasgow Antipsychotic side effect scale, every six months to monitor the effects of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence (NICE) guidance.

Track record on safety

Between February 2019 and September 2019 there were no serious incidents reported by this service which was lower than the five reported at the last inspection. We were unable to review Closed Circuit Television footage which would confirm that no serious incidents had occurred.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. Staff reported incidents clearly and in line with provider policy.

Staff understood the duty of candour. They were open and transparent; and gave patients and families a full explanation when things went wrong. We saw letters written to family members who had raised concerns, managers had responded promptly with an explanation and an apology.

Managers debriefed and supported staff and patients after any incident. We reviewed five records of debriefs and found all contained discussions around staff and patient welfare and lessons which staff could learn. Patients' involved in incidents were given a debrief which staff completed using an easy read form.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made because of feedback. As a result, the registered manager and the lead nurse attended a root cause analysis training course to improve their investigations of incidents.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Inadequate

Wards for people with learning disabilities or autism

At the time of the inspection the provider had not admitted any new patients since the previous inspection. We reviewed five patient records and found staff completed a comprehensive mental health assessment of each patient either on admission or soon after admission.

All patients had their physical health assessed soon after admission and most had this checked regularly during their time on the ward, However, we found that staff had not reviewed two patients' physical health since their admission.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans and positive behaviour support plans when patient's needs changed. Care plans were personalised, holistic and recovery-orientated.

Positive behaviour support plans were present and supported by a comprehensive assessment

Best practice in treatment and care

Staff used recognised rating scales such as the Health of the Nation Outcome Scale (HoNOS) and Model of Human Occupational Screening Tool (MOHOST) to assess and record severity and outcomes.

Staff participated in clinical audit, such as a care plan audit, an infection control audit and a health and safety audit.

Staff provided a range of care and treatment suitable for the patients in the service. This included a recovery model aimed at learning new skills for life and psychological interventions such as cognitive behavioural therapy (CBT).

Staff delivered care in line with best practice and national guidance from the National Institute of Health and Care Excellence.

Staff understood patients positive behavioural support plans and provided the identified care and support. Psychologists and occupational therapists created a positive behavioural support plan to help staff understand how to support patients best, these included red, amber and green behaviours and how best to address them.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. We saw examples in patient notes where staff had worked with patients using social stories to support them to understand going to the doctor and the dentist. Staff attended hospital appointments to see specialists with patients and stayed in hospital with them if they were admitted.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The speech and language therapist supported the service to design food choices which would support patient's sensory needs as well as their nutritional needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff supported patients to attend a local gym and others to take cooking lessons on site.

We did not see staff use technology to support patients. However, patients had access to computers on site to use alongside the occupational therapy team.

Skilled staff to deliver care

The service had a full range of specialists to meet the needs of the patients on the ward. This included doctors, nurses, support workers, occupational therapists, speech and language therapists and psychologists.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. This included learning disability, autism and positive behaviour support training.

Managers had a structure for inducting new members of staff in line with the care certificate standards, however we found, the induction checklist was not present in two staff member's records.

Managers supported staff through regular, constructive appraisals of their work.

The provider's target rate for appraisal compliance was 80%. At the time of the inspection the appraisal rate for the service was 100%. This had increased since the last inspection when the rate was 21%.

Managers supported staff through regular, constructive clinical supervision of their work.

The provider's target of clinical supervision for staff was 80%. At the time of the inspection 95% of staff were receiving monthly clinical supervision. The rate of clinical supervision reported during this inspection was higher than the 50% reported at the last inspection.

Managers made sure staff attended regular team meetings or gave information to those who could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The manager had arranged for staff to attend transition training to support them when discharging patients. Staff were offered other regular short training sessions in topics which were relevant to their work.

Managers made sure staff received any specialist training for their role. Staff had attended specialist training in learning disabilities and autism and epilepsy training.

Managers recognised poor performance, could identify the reasons and dealt with these. Between February 2019 and September 2019 managers had dismissed 12 staff because of inappropriate behaviour. This included three staff who were sleeping during their shift and one member of staff who had physically abused a patient, other staff were dismissed for non-attendance.

Multi-disciplinary and inter-agency team work

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. The manager had completed a project to ensure all staff had a voice in these meetings. Staff fed back that they felt they could speak up in meetings and raise concerns.

Staff made sure they shared clear information about patients and any changes in their care, including during daily handover meetings.

Ward teams had effective working relationships with other teams in the organisation and with external teams and organisations.

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

At the time of the inspection seven patients were receiving treatment under the Mental Health Act.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of 24 September 2019, 97% of the workforce in this service had received training in the Mental Health Act. The training compliance reported during this inspection was higher than the 67% reported at the last inspection.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy who attended the service twice weekly. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

The service had one informal patient however this patient was unable to leave the ward as they were under a Deprivation of Liberty Safeguard.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five statutory principles. As of 14 October 2019, 93.3% of staff had received training in the Mental Capacity Act. The provider stated that this training is mandatory.

Inadequate

Wards for people with learning disabilities or autism

There was one deprivation of liberty safeguards application in place at the time of the inspection and managers monitored staff to make sure they did them correctly.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff used picture cards and social stories to help patients to understand the decisions they needed to make. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff consulted professionals and family members to consider the patient's wishes.

Staff made applications for Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service did not complete audits to ensure that staff were following policy on the Mental Capacity Act.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Most staff were discreet, respectful, and responsive when caring for patients. During our inspection we completed a short observational framework for inspection (SOFI), which is a tool we use to be able to capture the experiences of people who use services who may not be able to express this for themselves. We observed one patient for 30 minutes and observed 28 interactions between staff and patients. All observations demonstrated positive and supportive interactions between staff and patients. We saw the patient was engaged in meaningful activities, staff were relaxed and knew how to interact with the patient in a positive way. However, separately from the SOFI we observed on two occasions, times when staff were imposing towards a patient.

Staff gave patients help, emotional support and advice when they needed it. Patients had a named nurse and a key support worker who could help them and gave them one to one time on a regular basis.

Staff used appropriate communication methods to support patients to understand and manage their own care, treatment or condition. We saw staff using communication picture boards, easy read literature and signing to communicate with patients.

Staff directed patients to other services and supported them to access those services if they needed help. Staff had supported patients to attend the gym, public transport and access events in the community.

Patients said staff treated them well and behaved kindly. We spoke to four patients, all said staff were kind and caring. We observed interactions with staff where patients told them they trusted them and expressed gratitude for the care the staff were giving to them. We saw that family members had sent compliments, stating that staff went above and beyond, and the care was excellent.

Family members said that staff went above and beyond their duty for their relative.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. They told us about two occasions where staff had raised concerns about another staff member's behaviour and managers had dismissed or disciplined that staff member.

Staff followed policy to keep patient information confidential. Staff locked records away or stored on a secure electronic system.

Staff had arranged for fun days and drama days on the ward for the patients and had visitors in various fields come to speak about their activities.

Involvement in care

Staff involved patients in decisions about their care. We observed one care planning meeting and saw the patient was engaged and treated as an equal partner in their care. We saw that staff had offered four patients of the five

reviewed, a copy of their care plan. Staff were supporting patients to develop a police passport with advice for police on how to support them if they encounter the patient in the community. An advocate offered patients empowerment meetings where they could discuss their wishes and create a written plan, the advocate then fed back to staff and formed part of the patient's care planning or discharge planning.

Staff made sure patients understood their care and treatment and found ways to communicate with those who had communication difficulties. We saw staff using communication boards and picture cards to help patients decide what they wanted to do and to explain what was happening.

Staff involved patients in decisions about the service, when appropriate. Staff facilitated weekly community meetings where patients could raise concerns and make requests.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could attend patient forums which was a local event with other services of similar types where patients could be involved in the planning of services and changes. The manager had implemented several changes requested by patients including laundry and computer facilities and displayed the result on a board on the wards.

Staff informed and involved families and carers appropriately. Family members attended discharge planning meetings and patient forums. We spoke with two family members. Both were involved in their relative's care and said staff kept them informed about their family member.

Staff helped families to give feedback on the service we saw that the service had received six compliments from family members who were very positive about the service provided. We saw an example of a complaint where the provider had been responsive to a request made by a family member.

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

Requires improvement

Access and discharge

People using the service stayed there longer than they needed to. At the time of inspection the average length of stay was 1423 days, this was lower than the 2160 days reported at the previous inspection but still higher than the national average. The longest length of stay was sixteen years and six months. The provider stated this was due to the complexity of the patients.

Staff ensured that patients received regular care and treatment reviews and kept an up to date log of the agreed actions. Care and treatment reviews included staff from external organisations such as the patient's local clinical commissioning group.

The service had three patients who were located away from their home area.

When patients went on leave there was always a bed available when they returned.

Staff sometimes moved patients between wards, however, this was always in the best interests of the patients, for example, so that the provider could renovate their bedroom.

Staff did not move or discharge patients at night or very early in the morning and introduced them to the new service slowly over time where possible.

The service had the same rate of delayed discharges in comparison to the previous inspection. We reviewed one transition plan and found that the service should have discharged the patient the day before the inspection. Staff had not recorded a reason for the delay and actions to be taken were overdue and had been left blank.

Staff supported patients when they were referred or transferred between services. Staff would attend the new service with the patient and work on social stories about moving to support them to understand the change.

The facilities promote recovery, comfort, dignity and confidentiality

Inadequate

Wards for people with learning disabilities or autism

Each patient had their own bedroom, which they could personalise. Patients had placed posters and textured items on their walls and others had chosen the colour of their bedroom when it was repainted.

The occupational therapist had arranged for a local artist to create some artwork for the ward to aid recovery and make the environment feel homelier. She had chosen themes for each ward and taken feedback from patients and staff. One art project included a tree which patients could add a photo and enjoy tracing the lines along the walls.

Patients did not have a secure place to store personal possessions in their bedroom, however, staff could place personal items in a safe.

Patients had access to rooms and equipment needed to support treatment and care, including a dedicated block for occupational therapy activities and large grounds with a basketball court, trampoline and swings. Patients could access this space usually with staff supervision if appropriate.

The hospital did not have an examination couch, but staff could examine patients in their bedrooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private and could use their own mobile phones if appropriate.

The provider had not fully considered and responded to the needs of patients with autism in the ward environment where doors would slam shut creating a noisy environment for anyone with sensory difficulties.

Some patients could make their own hot drinks and snacks other patients were supported by staff.

The service offered a variety of good quality food. Each day staff displayed a picture menu on a board and patients could make choices about which food to have. The service catered for individual nutritional needs and two patients had self-contained flats where they could prepare meals for themselves. Staff ran a breakfast club which ran over four weeks where staff taught patients to make a range of breakfast items which could also be vegan or vegetarian.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work. However, at the time of the inspection no patients had taken up these opportunities.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff facilitated regular community meetings where patients could raise issues. Staff supported patients to access local community facilities such as gyms and encouraged them to use public transport where appropriate.

Meeting the needs of all people who use the service

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Staff provided verbal information and easy read leaflets and posters.

The service could provide information leaflets available in languages spoken by the patients and local community on request.

Managers made sure staff and patients could get help from interpreters and some staff had training in basic sign language and Makaton.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

Patients knew how to complain or raise concerns. Staff displayed posters and easy read leaflets as well as offering verbal advice.

Staff understood the policy on complaints and knew how to handle them. Managers could discuss informal complaints in team meetings, individual staff supervision or community meetings. Staff escalated formal complaints to the service manager or the lead nurse.

The service received a low number of complaints.

This service received two complaints between February 2019 to September 2019, this was lower than the 13 from the previous reporting period, both were partially upheld. Staff had not referred any complaints to the ombudsman.

Inadequate

Wards for people with learning disabilities or autism

Managers investigated complaints and identified themes. Staff received feedback on lessons learned in team meetings and supervisions.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients and family members received feedback from managers after the investigation into their complaint. We saw two letters which senior staff had written to family members who had complained, following their investigation. The letters contained an explanation and an apology when appropriate.

The service received compliments reflecting that patients were satisfied with their care. This service received six compliments from February 2019 to September 2019.

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

Inadequate

Leadership

Leaders had not maintained oversight of all significant safety concerns which CQC had raised at previous inspections or from enforcement action issued in April 2019. Staff were undertaking observations for long periods of time without a change of activity, there were unmitigated risks such as blind spots, faulty staff personal alarms and broken CCTV in the ward environment.

The service had a high turnover of managers and did not have clear succession plans or support networks for new managers. However, the registered manager at the time of the inspection had made significant changes to staff morale, performance, working conditions, medicines management and the quality of the facilities.

The registered manager, consultant psychiatrist and lead nurse were visible in the service and supported staff to develop their skills and take on more senior roles. Leaders had identified their own learning needs and had attended courses to improve their skills for example a root cause analysis course.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Managers had arranged to redecorate patient's bedrooms and involved staff and patients in the decision making around this.

The service was working to improve their strategy to include access to the community by developing patients' skills.

Managers made sure staff understood what the provider had planned for the future of the service through team meetings and staff feedback events.

Staff had received training in the visions and values of the provider and understood how this applied to their own work.

Culture

The registered manager had undertaken a project to improve staff morale. The manager had arranged for staff to undertake additional training in observation and engagement and to give support workers a voice at team handovers.

All staff we spoke with fed back that they felt positive about the support and were proud to work at the service. They said they felt less stressed than they did before.

Staff told us the service had an open culture. Staff felt comfortable raising concerns and were able to give examples when a staff member had raised concerns about other staff members and management had taken them seriously. Managers fed back to all staff when they raised concerns and told them about the outcome.

Managers monitored poor performance and acted decisively when staff raised concerns. Between February 2019 and September 2019 managers had dismissed 12 staff for not meeting the provider's expectations.

The manager had completed a project to reduce levels of staff sickness levels. As a result, staff sickness had reduced from 8.3% to 5.2%.

The provider supported staff with their wellbeing through fortnightly wellbeing sessions led by a psychologist.

Governance

Managers had not put in place adequate checks to ensure oversight of significant concerns raised by the CQC in previous inspections or from enforcement action issued in

April 2019. Managers were not aware that staff were undertaking observations for long periods of time without a change of activity, that there were unmitigated risks such as blind spots, of faulty staff personal alarms or broken closed circuit television (CCTV).

Managers did not monitor or review how often staff had to complete observations outside of the provider's policy and had no oversight of how observations were allocated on each shift. In addition to this, managers did not ensure that staff were following policies and protocols.

Managers failed to ensure that the closed-circuit television (CCTV) system was working appropriately. Managers did not follow agreed actions from a previous inspection for auditing closed-circuit television footage. At the time of the inspection, we found the closed-circuit television system had not been working for three weeks. Managers and senior staff were not aware of this and had therefore not taken steps to resolve this issue. Managers had not completed random CCTV spot checks of historic footage during three weeks during September 2019 despite having agreed to complete bi-weekly audits to ensure that staff were recording physical restraints.

Staff met regularly to discuss the performance of the service, complaints, incidents and safeguarding. Team meetings followed a regular format however meeting minutes were not always detailed enough. Whilst staff kept track of the topics discussed at meetings, they did not always keep records of the details of the discussions, so minutes would not be sufficient to update staff who could not attend.

Management of risk, issues and performance

Whilst leaders managed performance using systems to identify, understand and monitor the service they were not robust enough to identify and reduce risks. Managers failed to highlight blind spots in the ward as within their environmental risk assessment. Due to this, managers did not provide enough staff on the wards to manage the risks appropriately.

Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care. Staff ensured that patients could access activities in the community when they were not on offer in the hospital for example a local gym and public transportation.

Managers kept a risk register for the service including any outstanding actions and their progress, however, the register did not identify all areas of risk, for example blind spots in the ward environment. Items included staff sleeping on shift, environmental repairs and actions from audits. Staff could add concerns to the risk register.

Managers developed suitable plans for emergencies, such as fire evacuations and issues with the patient environment. Staff could access these plans along with other risk assessments for the service.

Information Management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The provider reviewed this data and offered support to implement the changes needed to improve the service.

Engagement

Senior managers were accessible to all staff and regularly sent weekly bulletins and updates about matters which affected the service.

Staff supported patients and their families to attend patient forums which were offered by the provider. Patients could feed back to the service through annual surveys and monthly community meetings.

The registered manager listened to feedback from staff about morale, culture and concerns and took swift action to resolve them. When staff completed training sessions, the manager sought feedback from them about how useful it had been or how it could be improved.

Staff engaged external stakeholders such as clinical commissioning groups and the local authority in conversations which affected patients, however conversations that the service had with clinical commissioning groups surrounding discharge of patients and suitable placements were not always successful.

Learning, continuous improvement and innovation

Staff were committed to improving and innovating within the service. They had presented and implemented new ideas for activities such as drama days, fun days and breakfast club.

Inadequate

Wards for people with learning disabilities or autism

Staff had participated in projects to reduce over prescribing of antipsychotic medicines (STOMP) and reducing self-injurious behaviour. These were ongoing projects.

Staff were not participating in any research projects or benchmarking at the time of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all blind spots are identified and appropriately mitigated.
- The provider must ensure that staff alarms work when activated and all display panels show the correct location of each alarm.
- The provider must ensure that enough nursing staff of relevant grades are deployed to keep patients safe and to maintain observation levels in line with provider policy and national guidance.
- The provider must provide staff with clear, individualised plans for the provision of observations of patients.
- Managers must ensure that they have robust governance process to address concerns raised by staff and CQC.
- Managers must ensure they have appropriate monitoring of staff compliance to provider policies.
- Managers must ensure that the closed-circuit television system is fully functional and appropriate contingency plans are in place to prevent and detect failure.

Action the provider SHOULD take to improve

- The provider should ensure that staff regularly review patients' physical health.
- The provider should ensure that patients have a secure place to store personal possessions in their bedroom.
- The provider should ensure that the ward environment meets the needs of patients with autism.
- The provider should offer an examination couch for staff to use for physical health checks.
- The provider should review the progress of people using the service regularly to ensure that they do not stay in hospital longer than they need to.
- The provider should ensure that the registered manager receives support to ensure continuation of improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not identified all risks posed by blind spots in the ward environment. **This was a breach of regulation 12 (1) (2) (a) (b) (d)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider's alarm system did not work correctly. The provider had not ensured that there were sufficient staff to complete observations as prescribed. The provider had not ensured that staff completed observations in accordance with care plans, national guidance and the provider's policy. The provider had not ensured that observation care plans were completed in an individualised way. The provider had not ensured staff recorded all physical restraints following incidents **This was a breach of regulation 12 (1) (2) (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not maintained the CCTV to ensure it was fully functional. **This was a breach of regulation 15 (e)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had poor oversight of significant issues and adequate action to manage them was not always taken.

This section is primarily information for the provider

Enforcement actions

This was a breach of Regulation 17 (1) (2) (a) (b)