The Priory Hospital Hayes Grove

Quality Report

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Date of inspection visit: 21 and 22 January 2020
Date of publication: 20/03/2020

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

In this inspection, we only inspected the core service wards for people with a learning disability or autism. We did not inspect the other core services provided by The Priory Hospital Hayes Grove. When we inspected all four core services provided by the hospital in October 2018, we rated it as Good overall. At this inspection, we did not review the overall rating for the hospital.

Due to the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act to take immediate enforcement action and placed a condition on the provider's registration. This meant that the provider could not admit patients to Keston Ward until improvements had been made.

Our rating of wards for people with learning disability or autism went down. We rated it as inadequate because:

- The service did not always provide safe care. The ward environment was not entirely clean or suitable for the needs of autistic patients. The wards did not have enough permanent nurses. On some occasions, nurses used restrictive practices when therapeutic approaches may have been more appropriate. Staff did not always have the skills required to develop and implement good positive behaviour support plans. Many staff found it difficult to work with patients who displayed behaviour that staff found challenging. There had been two serious incidents of staff assaulting patients. The service did not have robust systems for ensuring that all staff were aware of risks and incidents.
- Staff did not always create holistic care plans. Some staff did not have care plans for specific physical health needs. Some care plans did not appear relevant to the patients. Care plans and risk assessments were not updated in a meaningful way.
- Managers did not ensure that staff received training or supervision. Permanent staff had not received supervision for six months. Agency staff made up a large proportion of staff working on the ward. They did not receive supervision. Agency staff were not required to have any experience of working with autistic patients. Managers did not have systems for assessing or monitoring the competency of agency staff.
- Staff did not always treat patients with compassion and kindness. We saw staff speaking to a patient abruptly. Patients said that some staff were rude and they found some staff intimidating. Temporary staff had a limited understanding of patients' needs.

However,

- Staff followed good practice with respect to safeguarding
- Staff provided treatments suitable to the needs of the patients cared for in a ward for people with autism and in line with national guidance.
- The ward teams included or had access to specialists required to meet the needs of patients on the wards.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- They actively involved patients and families and carers in care decisions.

Summary of findings

Contents

Good

The Priory Hospital Hayes Grove

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

Summary of this inspection

Background to The Priory Hospital Hayes Grove

Keston Ward is part of the Priory Hospital, Hayes Grove. It is a specialised mixed gender unit for adults of working age who have a diagnosis of Autistic Spectrum Disorder (ASD) with psychiatric co-morbidities. The service also admits people with ASD and mild learning disability. The unit had capacity for up to nine patients.

The provider was registered to provide care for the following regulated activities:

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

The service had a registered manager in place at the time of this inspection.

Our last inspection of Priory Hayes Grove was in October 2018. The ward for people with learning disabilities or autism were rated as good.

Our inspection team

Our inspection team included two inspectors, an inspection manager and a specialist advisor who had a professional background in nursing for patients with autism.

Why we carried out this inspection

This was a focused, unannounced inspection looking at the culture, safety and leadership of the service. The CQC carried out this inspection after receiving an anonymous whistleblowing concerns and receiving an increase in notifications of safety incidents.

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?

During the inspection visit, the inspection team:

- visited Keston Ward, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with two patients who were using the service;
- spoke with the registered manager, clinical services manager and the ward manager for Keston Ward;
- spoke with 12 other staff members; including doctors, nurses, occupational therapist, and a psychologist;
- spoke with an independent advocate;
- attended a multi-disciplinary meeting;
- looked at three care and treatment records of patients; and

Summary of this inspection

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We met with two patients. Patients spoke positively about the care and treatment they received from the consultant psychiatrist. They said the occupational therapist was nice. However, they said that staff frequently showed them no respect. They said that staff had been rude to them. Patients said they did not feel safe on the ward and they were fearful of agency staff. Both patients described incidents of staff being intimidating towards them. Patients said they could often hear other patients screaming and they found this distressing.

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.

Four patients were detained under the Mental Health Act. Statutory documents were completed and stored appropriately. A second opinion appointed doctor had authorised the use of medicines and electro-convulsive therapy for a patient who did not have capacity to consent to treatment.

Mental Capacity Act and Deprivation of Liberty Safeguards

Three patients were subject to deprivation of liberty safeguards.

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	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Good	Good	Good	Good	Good	Good

Notes

Inadequate

Wards for people with learning disabilities or autism

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

Summary of findings

SAFE

Our rating of this service went down. We rated it as inadequate because:

- Staff did not always have the skills required to develop and implement good positive behaviour support plans. Staff who were unfamiliar with the patients found it difficult to anticipate, de-escalate and manage challenging behaviour. As a result, they used restraint at times when therapeutic interventions could have been used instead. The ward staff were not participating in a restrictive intervention reduction programme.
- The ward had a poor track record on safety. There had been two serious incidents of assaults by staff on patients. Incidents, such as absconding or self-harm by swallowing, happened on more than one occasion before the ward took steps the prevent them. The service did not have adequate systems for ensuring all staff knew about incidents and risks. Discussions in handover meetings were not recorded. Staff did not recognise all incidents and report all incidents that should be reported. Staff did not hold de-briefing sessions after incidents. Two patients said they did not feel safe on the ward.
- Some areas of the ward were not clean. Clinical equipment was not clean and not stored appropriately.
- The service did not have enough nursing staff who knew the patients. Agency staff made up a high proportion of staff working on the ward. Many agency staff only provided a small number of shifts on the ward and had not had the opportunity to get to know patients. On some occasions staff were required to work long shifts without a break.
- Equipment identified to manage risks, such as communication tools and items to minimise self-harm, we not available on the ward.
- Staff did not update risk assessments after risk incidents.
- It was difficult for staff to access clinical information. The electronic patient record system was slow and it was difficult for staff to find information quickly.

However,

- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.

EFFECTIVE

Our rating of this service went down. We rated it as inadequate because:

- Staff did not all have the appropriate skills and experience to work with autistic patients. The service did not require agency staff to have any experience of working with autistic patients. Five of the 12 permanent health care assistants had started working on the ward in the three months before the inspection. The ward manager had been in post for five weeks. They did not have specific experience of working with autistic patients.

Inadequate

Wards for people with learning disabilities or autism

- Managers did not support staff. None of the permanent staff had had supervision for six months prior to the inspection. Managers did not have any systems for assessing or monitoring the competency of bank or agency staff. Staff did not feel supported. Staff who had recently joined the service said they found themselves in situations they found shocking and unable to deal with.
- Staff did not create care plans to cover all the needs patients presented. Some patients did not have sufficient care plans in relation to their physical health and personal care.
- Staff had not participated in clinical audit, benchmarking or quality improvement initiatives.

However,

- Staff provided some care and treatment interventions suitable for the patient group and consistent with national guidance. The consultant psychiatrist and psychologist were experienced in their roles and knew the patients well.
- Patients had some access to psychological therapy. An occupational therapist helped patients to engage in creative and recreational activities.
- Staff used recognised rating scales to assess and record severity and outcomes.
- Permanent nursing staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.

CARING

Our rating of this service went down. We rated it as requires improvement because

- Staff did not always treat patients with compassion and kindness. We observed staff speak with patients in a derogatory manner. Many staff had a limited understanding of the individual needs of patients.
- Patients said that staff were rude towards them. Patient said they were fearful of some of the agency staff and found some staff intimidating.
- The service did not actively seek feedback from patients.

However,

- Staff informed and involved families and carers appropriately.
- The service ensured that patients had easy access to independent advocates.

RESPONSIVE

Our rating of this service went down. We rated it as requires improvement because

- The design and layout of the ward was not appropriate to the sensory needs of autistic patients. The ward was noisy. Some areas of the ward were cold. The dining room was small with a lot of furniture, making it difficult to accommodate more than two or three patients. Male and female bedrooms were not situated in designated areas of the ward.
- The ward did not meet the needs of all patients who used the service. One patient with impaired mobility had a small bedroom. This meant that staff found it difficult to provide personal care.

However,

- Patients could make hot drinks and snacks at any time.
- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare. Discharge was rarely delayed for other than a clinical reason.

WELL-LED

Our rating of this service went down. We rated it as inadequate because:

- Some leaders did not have the skills, knowledge and experience to perform their roles. This meant it was difficult for these leaders to provide guidance, coaching and mentoring for less experienced staff.

Inadequate

Wards for people with learning disabilities or autism

- Staff had very little understanding the of provider's vision and values and how they were applied in the work of their team. The service did not promote its vision and values on the ward.
- Most staff did not feel respected, supported or valued. Many members of staff said they were unsupported. Whilst they felt able to raise concerns without fear of retribution, they felt that no-one listened to them and nothing changed in response to their concerns. Staff said they didn't receive any support after incidents.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level. Risks were not always managed well. There were no systems for assessing and monitoring staff competency. There were no action plans to address any of the concerns we raised.
- Ward teams did not have access to the information they needed to provide safe and effective care. Managers found it difficult to access data on the use of restrictive interventions
- Staff had not engaged actively in local and national quality improvement activities.

However,

- Hospital managers and senior clinicians regularly visited the ward. They knew many of the permanent staff, patients and patients' families.

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Safety of the ward layout

The ward layout allowed staff to observe all parts of the ward. Keston was a small ward with all rooms leading off a single corridor. The service had completed an audit of blind spots in October 2019. The audit found that there were some blind spots, especially in patients' bedrooms. The audit states that these risks have been assessed as being acceptable and are mitigated by staff awareness and observations.

Staff had mitigated the risks presented by ligature anchor points adequately. The hospital had completed an audit of ligature risks in October 2019. This audit listed ligature points in each area of the ward. Each risk was given a score to indicate its severity. The document gave details of the action staff would take to manage the risk. For most ligature points, the risk was mitigated by staff awareness and observations.

The ward usually complied with guidance on eliminating mixed-sex accommodation. All bedrooms had en-suite facilities. The ward had a lounge designated for female patients only, although this was closed at the time of the inspection due to a redecoration of the ward. However, the bedrooms were not separated into male areas or female areas. Staff were not sufficiently vigilant to mitigate the risk presented by the lack of segregation. For example, during the inspection, we saw a male patient looking into the bedroom of a female patient. This could have compromised the privacy and dignity of the female patient.

Maintenance, cleanliness and infection control

Some areas of the ward were not clean. The patients' dining room was not clean. There was old food encrusted on the insides of the microwave. A dustpan covered with dirt had been left on the floor. The fridge was reasonably clean, but staff had not put labels on open bottles and condiments to show the date they were opened. This meant that patients could have been eating food that had

passed its recommended use by date. We saw that a patient's breakfast had been left for them on top of the microwave until 11.30am. The food was not covered or labelled.

However, the ward was being redecorated at the time of the inspection. We saw domestic staff cleaning the ward throughout the inspection. Furniture was generally of good quality and, aside from the cleanliness of the dining room, the ward was well-maintained.

Staff adhered to infection control principles, including handwashing. The hospital had completed an infection control audit in 2019. The audit showed the ward had passed all the checks. Managers discussed compliance with guidance on infection prevention and control at monthly clinical governance meetings. However, when we arrived on the ward the disinfecting hand gel dispenser was empty. There was no hand gel in the bedroom of a patient who required personal care.

Clinic room and equipment

The clinic room was not well organised and equipment was not kept clean. The clinic room was very small. Staff kept emergency equipment in the nurses' office. The cupboards used for storing medicines were not clean and they were poorly organised. All medicines were stored as stock medicine, rather than being arranged in separate containers for each patient. A metal spoon on the dispensing tray was not clean. A pestle and mortar used for crushing medicines had not been cleaned. One patient used a cordial when taking their medication. This had not been kept in the fridge and the staff had not recorded when the cordial had first been opened. The label stated that the cordial should be used within 21 days of opening.

Staff did not maintain equipment well or keep it clean. The blood pressure monitor, pulse oximeter and other equipment used for baseline observations were stored in the nurses' office. The equipment used for monitoring blood pressure and the stethoscope were not clean. The testing sticks used to analyse urine had expired in 2018. Staff were still using them. The outside of the packet was not clean. Equipment used for measuring blood glucose levels was not stored in its packaging. It was dirty. This could affect the accuracy of the readings. There was no instruction booklet with the equipment to inform staff of how to use the equipment.

Safe staffing

Nursing staff

The service had four vacancies for registered nurses out of an establishment of six. This amounted to a vacancy rate of 66%. The service had five vacancies for healthcare assistants out of an establishment of 17. This amounts to a vacancy rate of 29%.

Managers had calculated the number and grade of nurses and healthcare assistants required. The level of staffing was calculated on the number of patients and the level of observations patients required.

The number of nurses and healthcare assistants matched this number on most shifts. However, between 30 December 2019 and 19 January 2020 there was one shift when there was no registered nurse on duty. During this period there were four shifts that were staffed entirely by bank and agency staff. Staff said they sometimes felt that shifts were short staffed. Staff told us there had been some shifts when they had not been able to take a break. On these occasions, the hospital manager said they could leave the hospital early or they would be paid for the additional time they had been on the ward. This meant that staff would have been working for 12 consecutive hours without a break.

The ward manager could adjust staffing levels daily to take account of case mix. For example, the ward manager increased the number of healthcare assistants on duty when patients required enhanced observations or when a patient required an escort to an appointment.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. In December 2019, the service had deployed 15 registered nurses employed by an agency across 69 shifts. During that month, the service had deployed 36 healthcare assistants employed by an agency. This included 20 healthcare assistants who had worked just one shift. This meant that, in total, 62 people had worked on the ward during that month. This could be challenging for autistic patients who were inclined to prefer daily routines and needed to know what is going to happen each day. One patient commented that they never knew who was coming on shift. Another patient said that they didn't know the names of any of the agency staff.

When agency and bank nursing staff were used they received an induction. During their induction staff received information about each patient on the ward, including an explanation of each patient's care plan. New staff were also shown around the ward and introduced to patients.

A member of staff was present in communal areas of the ward at all times. Throughout the inspection, we saw that a member of staff was based in the main corridor.

Staffing levels usually allowed patients to have regular one-to-one time with staff, to have escorted leave and to engage in ward activities. In order to care for the seven patients, there were eight staff on duty during the day and seven on duty at night. This included two registered nurses during the day and one at night. This meant there were enough staff to provide regular one-to-one time with patients. However, the inconsistency of staffing meant that patients may not always have been able to speak with a member of staff they were familiar with.

There were enough staff to carry out physical interventions (for example, observations, restraint and seclusion) safely and staff had been trained to do so. If the service required additional staff for short periods of physical intervention, they could ask for staff from other wards at the hospital.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The consultant psychiatrist was available at the hospital for three days a week and attended the ward every Wednesday and Friday. A doctor was available at the hospital during the week. An on-call duty doctor was available outside office hours.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. Staff compliance with mandatory training courses was 84%. The hospital required agency staff to have completed mandatory training in safeguarding, moving and handling and preventing and managing violence and aggression.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff did a risk assessment of every patient. These risk assessments were incorporated in to the patients' care plans. However, staff did not always update assessments after risk incidents. We reviewed the record of one patient who had been involved in a number of incidents in November and December 2019 and January 2020. These incidents involved deliberate self-harm and absconding. The risk assessment had not been updated since October 2019.

Management of patient risk

Staff did not always identify the changing risks to, or posed by, patients. Risk assessments showed that patients were at risk of self-harm, self-neglect, absconding or non-compliance with medication. Risk management plans instructed staff on how to respond to incidents. For example, one risk management plan said that if a patient was banging their head, staff should block the corners of the room and place a cushion between the patient's head and the wall. One risk management plan said that the patient could use traffic light cards to express how they were feeling and an ice-pack to use as an alternative to banging their head. However, neither the ice-pack or the traffic light cards were available on the ward. Other actions to manage this patient's risks were out-of-date and did not relate to the specific risk the patient presented at the time. Whilst the staff held handover meetings at the start of each shift, these meetings were not recorded. This meant that staff were required to absorb and remember information about all the patients during a short meeting. This could be difficult for staff who were unfamiliar with the patients.

Staff followed good policies and procedures for the use of observation and for searching patients or their bedrooms. Four of the seven patients were subject to enhanced observations by either one or two members of staff. The service had a policy on observation and engagement with patients. Staff searched patients bags when they returned from leave if there was a risk that the patient may be bringing prohibited items onto the ward.

Use of restrictive interventions

During our interviews with the ward manager and the clinical service manager, it was very difficult to work out how many incidents of restraint and rapid tranquilisation had taken place on the ward. Incidents involving restraint and rapid tranquilisation were not specifically discussed in clinical governance meetings. The absence of any data relating to restrictive interventions meant that it was difficult for managers to monitor trends or quickly identify any increases in its use.

Inadequate

Wards for people with learning disabilities or autism

The ward was not participating in a restrictive interventions reduction programme. The minutes of a clinical governance meeting in October 2019 state that the ward was asked to complete an audit of restrictive interventions. The results of this audit were scheduled to be discussed at the

meeting in November. However, there was no evidence that this audit had been carried out in the minutes of meetings in November or December.

Staff used restraint only after de-escalation had failed, although the efforts made to de-escalate situations were often limited. For example, during an incident in January 2020 a patient was displaying autistic characteristics and experiencing fixated thoughts. Staff attempted to de-escalate the situation by asking the patient to stop the behaviours. This incident quickly escalated, leading to restraint in a seated position and rapid tranquilisation using an intramuscular injection. There was no evidence of the staff using planned, therapeutic interventions that are recommended in national guidance. However, when staff used restraint they used appropriate techniques and made comprehensive records of the incident including the type of restraint used, the names of the staff involved in the restraint, the role each member of staff carried out and the length of time the restraint lasted.

Staff did not fully comply with National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We reviewed three incidents involving rapid tranquilisation. All these incidents involved the same patient. Two of these incidents were a response to the patient causing harm to themselves by banging their head against a wall. After one incident the staff recorded the observations of the patient's blood pressure, pulse, respiration, temperature and oxygen saturation. Following another incident, the patient declined observations. Following a third incident, it appeared that staff took observations a number of hours after the incident. Staff did not systematically follow NICE guidance in monitoring side effects every hour until there were no further concerns about the patient. However, the patient was receiving enhanced, one-to-one observations from staff who would have been able to notice any deterioration in the patient's condition.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. Training in safeguarding was mandatory for both permanent and agency staff.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Potential safeguarding concerns were discussed by senior staff at daily handover meetings. Safeguarding concerns were reported to the local authority and, when necessary, the police. The hospital notified the Care Quality Commission of safeguarding alerts in accordance with regulations.

Staff access to essential information

Most information was recorded on the electronic patient records. Information needed to deliver patient care was available to permanent staff when they needed it and was in an accessible form. Some agency staff who worked at the hospital on a regular basis could access the electronic record. There were two computers on the ward shared between the ward manager and eight staff on duty. We found the electronic system to be slow. This meant that it was difficult for staff to access information about patients quickly.

Medicines management

Staff did not always follow good practice in medicines management including transport, storage, dispensing, administration, medicines reconciliation, recording, disposal and did it in line with national guidance. The hospital employed a specialist pharmacy service to oversee the management of medicines. A pharmacist visited the hospital each week to review medicine

charts and highlight any errors. The hospital's managers reviewed the pharmacist's reports. However, during a brief review of medicine charts, we found that one patient had received an overdose of medicine used, when required, to sedate the patient when they were agitated or anxious. The patient's medicine chart stated that the patient could receive up to two doses each day. On one day in January 2020, the staff administered three doses. We informed the service of this error and they completed an incident report. Medicine charts did not include a photograph of the patient. Photographs would assist staff who were unfamiliar with patients to make sure they were giving the medicine to the correct patient.

Inadequate

Wards for people with learning disabilities or autism

Staff reviewed the effects of medication on patients' physical health regularly. For example, staff regularly carried out blood tests for a patient receiving anti-psychotic medicine. This meant that the staff quickly identified that the patient was becoming neutropenic.

Track record on safety

There had been one serious incident in the last 12 months. This involved an allegation by a patient that they had been sexually assaulted by a member of staff. The matter had been reported to the local authority safeguarding team and was being investigated by the police. The member of staff had been suspended.

Reporting incidents and learning from when things go wrong

Staff had not reported all incidents that they should report. For example, staff had experienced a number of difficulties in providing personal care to one of the patients. Staff had not recorded any incidents relating to this. This meant that managers were not necessarily aware of the difficulties staff were having and these concerns were not being addressed. However, staff had recorded incidents relating to violence and aggression, deliberate self-harm and patients being absent without leave.

Details of incidents and feedback from investigations was not always discussed with all the staff. Staff said they discussed incidents at handover meetings. However, staff also said that on some occasions they were not told about incidents. Handover meetings were not recorded. Whilst staff were encouraged to read the patients' notes and the records of incidents, this was not always possible, especially when the ward was busy. Staff said they found out about incidents by talking to their colleagues. One member of staff said that they had not been told about a recent restraint of a patient.

There was little evidence to show that changes had been made as a result of feedback from investigations into incidents. Between October 2019 and January 2020, there were a number of repeated incidents. For example, on October 2019, a patient absconded and attempted to jump onto nearby railway lines. This happened again three days later. At the end of October 2019, a patient swallowed a battery from the television remote control. The patient swallowed another battery again 10 days later. The repetition of these incidents indicates that staff had not responded sufficiently to the first incident to ensure the patient's safety.

Staff were not always debriefed or received support after a serious incident. Some staff said there were no discussions or de-briefings after incidents.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Inadequate

ssessment of needs and planning of care

We reviewed three care records during the inspection. These records did not demonstrate good practice in terms of assessment, treatment and risk management.

Staff completed a mental health assessment of each patient. Assessments of patients' mental health were reviewed by the multidisciplinary team at weekly ward rounds and recorded in the patients' records.

Staff assessed patients' physical health needs during their admission but did not always create effective care plans to manage the health needs identified. On one patient's record, we found an epilepsy care plan that contained details of possible signs of a seizure and explained what staff should do pre-seizure, during the seizure and post-seizure. However, other records showed that staff had not developed care plans that met all the patient's needs identified during assessments. For example, one patient had chronic constipation but there was no care plan to address this. The record of another patient showed that there had been blood in their faeces. There was no care plan in place to ensure that staff monitored this. The notes for this patient also stated that they had a graze on their arm that had the potential to develop into a pressure sore. There was no care plan in place to ensure staff were aware of this and knew the steps to take to prevent a pressure sore developing.

Care plans were not always personalised, holistic and recovery-oriented. This did not always cover patients' specific needs relating to autism. On one care plan, goals and interventions did not relate to the patient's current

needs. The goals and interventions on the care plan related to an historic incident that the patient was no longer concerned about. Also, care plans were not designed in a way that would make it easy for new staff to quickly understand the patient's needs. For example, there were no patient profiles, no summary sheets of patient's sensory needs and no summaries of personal behaviour support plans.

Staff had not updated care plans in any meaningful way. One patient had two care plans that were almost two years old. Although they had been updated on 40 occasions, each update stated that no changes to the care plan had been made.

Best practice in treatment and care

Staff provided some care and treatment interventions suitable for the patient group although the service failed to provide the consistency and structure that autistic patients needed. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Keston Ward provided a specialist service, treating psychiatric illnesses in patients with an underlying autistic spectrum disorder. This meant that many patients presented with complex needs such as obsessive-compulsive disorders, eating disorders, schizoaffective disorders, post-traumatic stress disorders, depression and psychosis. The multidisciplinary team met each week to discuss each patient and review their formulations. Treatment was provided through medication, including anti-psychotic medicines and anti-depressants. In exceptional cases, the service used electro-convulsive therapy. A psychologist worked across the hospital. They were involved in the multidisciplinary team meetings and formulations. An occupational therapy assistant had a good

understanding of the needs and interests of all the patients and supported patients to engage in therapeutic and recreational activities they enjoyed. For example, they had supported a patient to use a computer to enable them to watch films and listen to music. They had supported other patients in therapeutic drawing and colouring. However, during the inspection, we saw that patients spent a lot of time in their bedrooms during the day, either sleeping or not engaging in any sort of activity. Senior clinicians acknowledged that the ward was not providing the continuity and structure that autistic patients needed. Whilst there was considerable experience of working with complex patients among the senior clinicians, this was not reflected in the ward staff, of whom many had little or no experience of working with autistic patients. There was little evidence of therapeutic approaches being used on the ward. For example, during an incident, staff attempted to stop a patient engaging in possible autistic behaviour without offering therapeutic support or interventions. The patient became very upset and attempted to assault staff.

Staff usually ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff accompanied patients to appointments at the local hospital for specialist assessments when necessary. However, staff had not responded to a patient who had blood in his faeces and a risk of pressure sores.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. At least three patients had conditions relating to eating disorders. The hospital provided a specialist service for patients with eating disorders on another ward. This meant that patients on Keston were supported by a specialist dietician who assisted with the formulation of diet plans. During the inspection, one patient was receiving nutrition through a nasogastric tube. Records showed that staff checked the nasogastric tube had been inserted correctly before feeding the patient.

There was little evidence to show that staff supported patients to live healthier lives. There were no programmes for patients to engage in healthy activities. We saw that some patients spent a lot of time in bed during the day.

Staff used recognised rating scales to assess and record severity and outcomes. Staff recorded and updated Health of the Nation Outcome Scores (HoNOS) for each patient.

Staff did not participate in clinical audit, benchmarking and quality improvement initiatives. Whilst there was evidence of standard audits of the environment, there were no audits relating specifically to clinical matters. At the monthly clinical governance meeting, staff were invited to give updates of matters relating to clinical effectiveness. There were no updates for Keston Ward in October, November or December 2019.

Skilled staff to deliver care

Inadequate

Wards for people with learning disabilities or autism

The service had access to the range of specialists required to meet the needs of patients on the ward.. For example, a consultant psychiatrist visited the ward and reviewed patients at least twice a week. A dietician worked with patients with eating disorders.

Staff were not experienced and did not always have the right skills and knowledge to meet the needs of the patient group. All the permanent staff had completed a one-day training course on autism. However, there was no requirement for agency staff to have had any experience of working with autistic patients prior to them coming to the hospital. This meant that nurses leading a shift may have very limited experience of managing the complex needs of patients. Five of the 12 permanent healthcare assistants had been working on the ward for less than six months. Staff who had recently begun working on the ward said they had found themselves in

situations they found very difficult to deal with. For example, a healthcare assistant who had started work in the ward shortly before the inspection said they had been involved in restraining a patient before they had done any restraint training. They said they did not feel safe. They said that this was the first time they had worked in healthcare and they had found the situation shocking. Another healthcare assistant said that permanent staff were put under a lot of pressure because of the number of agency staff. They said they didn't always feel safe when carrying out restraints.

Managers provided permanent staff with an induction. Staff spent their first two weeks shadowing experienced members of staff and completing mandatory training. Inductions also involved an orientation to the ward, reading policies and understanding procedures. However, one member of staff said that had been required to restrain a patient before they had received training on how to do this. This significant risk of injury to that member of staff, their colleagues and the patient.

Managers did not provide staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). The service had not provided supervision to the permanent staff for over six months. Staff said they were unsupported, with no one to talk to about their concerns. Bank and agency staff did not receive supervision.

Managers completed annual appraisals of permanent members of staff.

The ward held team meetings for permanent members of staff. The ward had held team meetings in August, September and December 2019. During these meetings staff discussed changes to the ward, incidents and policies and procedures.

Managers had not identified the learning needs of staff and had not provided them with opportunities to develop their skills and knowledge. None of the staff were involved in any development programmes. Staff said they were frustrated at not having had the opportunity to meet the new ward manager so the ward manager could find out about their experience and understand what they do.

Managers had not ensured that staff received the necessary specialist training for their roles. Staff said that training was insufficient. Staff said they needed more specific training and that very few staff had experience of working with patients with autism.

Managers dealt with serious instances of poor staff performance. For example, the service suspended a member of staff immediately after receiving an allegation of sexual assault. The service also suspended two members of staff who failed to report an incident after they witnessed an agency nurse assault a patient. However, the service did not have systems for assessing and monitoring the competency of bank or agency staff. This meant that the service may not be able to identify poor performance or errors in professional practice.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. The service held a multidisciplinary team meeting once a week. The consultant psychiatrist, ward manager, doctor, occupational therapist, ward doctor and psychologist attended the meeting. During the meeting, the multidisciplinary team discussed each patient's progress, current presentation, incidents and any plans for the patient to move on to another placement.

The ward teams had effective working relationships, including handovers, with other staff at the hospital. For example, the dietician based on the ward for patients with eating disorders had regular contact with patients on Keston Ward.

Inadequate

Wards for people with learning disabilities or autism

The ward teams had effective working relationships with teams outside the organisation. For example, the ward held regular clinical treatment reviews with the patients' commissioners. The multidisciplinary team sought second opinions from clinical teams outside the service when appropriate.

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

Staff were not all trained in the Mental Health Act and did not necessarily have a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Agency staff were not required to have completed mandatory training in the Mental Health Act. Staff who had recently joined the service had not had any training in the Mental Health Act.

Staff had access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. A Mental Health Act Administrator was based at the hospital.

Patients had access to information about independent mental health advocacy.

Staff requested an opinion from a second opinion appointed doctor when necessary. We reviewed the certificates for authorising treatment for three patients. Copies of certificates signed by second opinion appointed doctors were stored with the patients' medicine administration charts.

Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. The original versions of statutory documents were kept by the Mental Health Act administrator.

Staff carried out audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. Managers discussed a Mental Health Act audit during a clinical governance meeting in November 2019. This audit found that improvements were needed in the completion of capacity assessments. The hospital had created an action plan to address this.

Good practice in applying the Mental Capacity Act

Staff were not all trained in the Mental Capacity Act and did not necessarily have a good understanding of the Mental Capacity Act, the Code of Practice and the guiding principles. Agency staff were not required to have completed mandatory training in the Mental Capacity Act. Staff who had recently joined the service had not had any training in the Mental Capacity Act.

Three patients were subject to Deprivation of Liberty Safeguards.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. For example, the service was arranging a best-interests meeting with professionals, a patient and their family to discuss the possibility of the patient moving to another placement.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients did not always demonstrate that they were discreet, respectful and responsive, or that they were providing patients with help, emotional support and advice at the time they needed it. We observed staff speaking with a patient in a derogatory manner when there was clearly an opportunity for the staff to provide a positive, caring intervention.

Patients did not say that staff treated them well or behaved appropriately towards them. We conducted interviews with two of the seven patients. Patients said they felt that only a small number of staff genuinely cared about them. They said that staff frequently showed them no respect when speaking with them. They said that staff had been rude to them. Patients said they did not feel safe on the ward and they were fearful of agency staff. Both patients described incidents of staff being intimidating towards them. Patients said they could often hear other patients screaming and they found this distressing. However, patients did say that the consultant psychiatrist and occupational therapist were both very nice.

Staff did not always understand the individual needs of patients, including their personal, cultural, social and religious needs. Given that there were so many staff

working on the ward, it was difficult for all staff to have a good understanding of patients' background, social circumstances and needs. However, staff who had worked at the hospital for some time knew the patients very well.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment. The consultant psychiatrist met with each patient at least once a week. They said this meant they had a good rapport with patients and were able to talk to them about their care and treatment.

Staff did not involve patients in decisions about the service or provide opportunities for patients to give feedback on the service they received. There was a record of one community meeting that was held in November 2019. The records showed that none of the patients had attended this meeting. Each month, hospital managers reviewed patients' feedback, including patient satisfaction surveys and complaints. In October, November and December 2019, none of the feedback was from patients on Keston ward.

Staff ensured that patients could access advocacy. An advocate visited the ward each week.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. For example, some patients' families visited patients regularly, attended care and treatment reviews and took patients out on leave. However, the service did not have any formal systems to receive feedback from families or other carers. One patient told us that their family had made a complaint about the service.

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

Requires improvement

Bed management and discharge

The ward could accommodate up to nine patients. During the inspection there were seven patients on the ward. Patients were admitted from London and South-East England. Most patients had been on the ward for a long time. The ward provided their primary place of residence. Four patients had been on the ward for more than five years. One patient had been on the ward for 18 months and two patients had been admitted in the past year.

Discharge and transfers of care

Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. Decisions about patients' discharge were made collaboratively with commissioners and carers, usually at care and treatment reviews. During a multidisciplinary team meeting during the inspection, staff were actively looking to discharge one patient and were exploring options for alternative placements with the patient's commissioners. Staff felt that all other patients on the ward were settled. Staff recognised that any transfer to other placements could be unsettling and disruptive to the patient. There had been no delays to discharge other than for clinical reasons.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. All bedrooms had ensuite facilities. However, bedrooms were small.

Staff and patients had limited access to rooms and equipment to support treatment and care. The dining room was small and would feel very crowded if there were more than three patients in there. During the inspection the female lounge and communal day area were closed for redecoration. There were no rooms that could be used for therapies, recreational activities or groups.

There were no quiet areas on the ward or a room where patients could meet visitors other than in bedrooms.

Patients had access to outside space. Patients had unrestricted access to a garden.

Patients could make hot drinks and snacks throughout the day and night. There was an area of the dining room where patients could make drinks and prepare food.

Patients' engagement with the wider community

Inadequate

Wards for people with learning disabilities or autism

When appropriate, staff ensured that patients had access to education, work and other activities in the community. One patient had completed an application to become a volunteer at a nearby animal rescue centre. Staff supported another patient to go to a local snooker club.

Staff supported patients to maintain contact with their families and carers. The service encouraged families to be involved in patients' care and treatment. Families visited patients, facilitated patients leave from the ward and attended meetings.

Meeting the needs of all people who use the service

The service had not made sufficient adjustments for disabled patients. This meant the ward was not a suitable environment for patients with autism. For example, the acoustics on the ward were poor. The temperature, sound and lighting on the ward could not be controlled to meet the specific needs of patients. The ward did not provide a homely environment. There were frequent vibrations cause by people closing doors. The service did not have specific tools or equipment on the ward to assist patients with communication. One patient required personal care and staff assistance with transfers from their bed to a wheelchair. The size of the room meant that staff had to move the bed to the side of the room in order to transfer the patient. Further, the patient's bathroom was very small. This meant it was very uncomfortable and difficult for the patient to use the toilet.

Listening to and learning from concerns and complaints

Between October and December 2019, the hospital had received one complaint relating to Keston Ward.

Staff knew how to handle complaints appropriately. Managers at the hospital reviewed complaints each month at clinical governance meetings. During these meetings, managers reviewed the findings of any investigations and, when complaints were upheld, considered actions to prevent similar incidents happening again. Complainants received a written response with details and the outcome of any investigation.

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

Inadequate

Leadership

Leaders did not all have the skills, knowledge and experience to perform their roles. Senior clinicians had considerable knowledge and experience of working with this group of patients who all had complex needs. However, the ward manager had only been in post for five weeks. They did not have any specific experience of working with patients with autism. The clinical services manager was supporting them through weekly supervision sessions. This lack of experience meant it was difficult for them to understand the therapeutic needs of patients or provide coaching and leadership to inexperienced staff on the ward.

Leaders were visible in the service and approachable for patients and staff. Senior clinician and managers frequently visited the ward and were well known to permanent staff. However, one member of staff said that managers only visited the ward when staff had done something wrong.

They felt that managers only looked at negative aspects of the work and did not provide any positive feedback about the things that had gone well. They found this demoralising.

Culture

Not all staff felt respected, supported and valued. Feedback from staff about their experience of working at the hospital was mixed. One member of staff was very positive about the changes on the ward that had happened since the new manager had begun in post. They said the manager was very involved in patients' care and the quality of the service had improved. Other staff said they had received no support and didn't feel that managers listened when they raised concerns. Staff who were new to the service said they had very little experience of working in healthcare and they had found the ward shocking. Staff said they didn't receive any support after incidents.

Staff felt able to raise concerns without fear of retribution, although some staff felt that nothing changed when they did raise concerns. One member of staff said that they don't speak up about issues anymore because nothing gets done. Another member of staff said that people had to

raise concerns several times before managers took any notice. However, some staff said they would speak to the on-call manager or the clinical services manager if they had any concerns.

Managers dealt with serious poor staff performance when needed. For example, staff were suspended immediately after allegations of assaults on patients. However, the service did not have mechanisms for assessing the performance and competency of bank and agency staff.

Teams did not work well together and where there were difficulties managers did not deal with them appropriately. A member of staff said there had been two team meetings at which staff raised concerns but nothing was done because there had been no agreement.

Governance

Overall, the governance of the service was weak. The ward did not have sufficient systems and processes in place to ensure a good quality service. The ward was not clean. The ward environment was not designed to meet the specific sensory needs of the patients. Ward staff did not have experience of working with the complex, and at times challenging, needs of patients. Managers found it difficult to access data relating to the number of incidents, restraints and rapid tranquilisation. Managers had not provided supervision to permanent staff for six months. Managers did not have systems for assessing the competency of bank or agency staff. The ward had a high level of vacancies. There were insufficient systems in place to ensure that all staff coming onto the ward were aware of the risks patients presented. The service did not have an action plan in place to address the concerns that we found.

There was a framework of what must be discussed at a ward level and hospital-wide level to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. During clinical governance meetings for the hospital in October, November and December 2019 there was some discussions about incidents on Keston Ward. For example, the meeting in October reviewed four safeguarding referrals and discussed a patient who was acutely psychotic. At the ward-based team meeting in December 2019, staff discussed how best to provide support to specific patients and how to respond when patients became agitated. However, only nine staff, out of the 62 staff who worked on the ward during that month attended the meeting. The notes of the team meetings were not very clear. Even if other staff took time to locate and read the notes, they may have found them difficult to understand.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. The ward worked with commissioners to review care and treatment and plan patients' discharge.

Management of risk, issues and performance

The hospital maintained a risk register. Senior staff discussed the hospital's risk register at monthly clinical governance meetings. The highest risks related to hospital security, poor evacuation in the event of a fire, compliance with the Disability Discrimination Act, patients absconding to smoke cigarettes and ligature risks on another ward. The risk register did not reflect the risk highlighted by staff. Staff were mainly concerned about a lack of permanent staff, lack of support to staff and staff being not able to manage patient incidents.

Information management

Staff did not have access to the equipment and information technology needed to do their work. The information technology infrastructure did not appear to work well. There were only two computers on the ward. The system for recording and accessing patients' records was very slow. This meant that it was time consuming for staff to record information and difficult for staff to access critical information quickly.

Information governance systems included confidentiality of patient records. All patient records were stored on a secure electronic system.

Team managers did not have access to information to support them with their management role. Managers found it difficult to access information about the number of incidents, restraints and rapid tranquilisation. This meant that it was difficult for managers to identify trends in patients' behaviours and the use of restrictive interventions.

Staff made notifications to external bodies as needed. For example, the hospital sent notifications to the Care Quality Commission in accordance with the Care Quality Commission Regulations 2009.

Inadequate

Wards for people with learning disabilities or autism

Engagement

Patients and carers had limited opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff did not actively seek feedback from patients and patients were not involved in making decisions about changes to the ward.

Learning, continuous improvement and innovation

Staff were not given the time and support to consider opportunities for improvements and innovation. None of the staff were involved in research, accreditation schemes or quality improvement initiatives.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that all areas of the ward are kept clean.
- The service must ensure that clinical equipment is clean and well maintained.
- The service must ensure that care and treatment is designed in a way that accommodates the clinical needs of patients. This includes consistency of staff and therapeutic responses to patients' behaviour.
- The service must ensure that staff update risk assessments after serious incidents.
- The service must ensure that staff are aware of any incidents that have happened on the ward and fully aware of the risks presented by or to patients.
- The service must ensure that care plans are in place to address patients' physical health needs.
- The service must ensure that that it deploys sufficient numbers of suitably qualified, skilled and experience staff to meet patients' needs.
- The service must provide staff with support, training, professional development and supervision.
- The service must ensure that all staff who are involved in restraining patients have received training in how to restrain patients safely.
- The service must ensure that staff protect patients' privacy and dignity and that they treat patients in a respectful manner.
- The service must ensure that facilities and bedrooms were appropriate to meet the needs of all patients.

Action the provider SHOULD take to improve

- The service should ensure that patient's bedrooms are divided into male and female areas of the ward.
- The service should ensure that it has systems to collect data on the use of restrictive interventions.
- The service should ensure that physical observations are carried out after administering rapid tranquilisation and record when a decision is made that these observations are no longer required.
- The service should include photographs of patients on medicines charts to ensure that medicines are being given to the correct patient.
- The service should that staff record all incidents, including those related to difficulties in providing personal care to patients.
- Staff should ensure that care plans and risk assessments are updated.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessment or medical treatment for person detained under the Mental Health Act 1983 Treatment of disease, disorder or injury.

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Assessment or medical treatment for person detained under the Mental Health Act 1983 Treatment of disease, disorder or injury.

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
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Assessment or medical treatment for person detained under the Mental Health Act 1983 Treatment of disease, disorder or injury.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Assessment or medical treatment for person detained under the Mental Health Act 1983 Treatment of disease, disorder or injury.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Assessment or medical treatment for person detained under the Mental Health Act 1983 Treatment of disease, disorder or injury.