Whorlton Hall

Whorlton Village
Barnard Castle
County Durham
DL12 8XQ

Quality report

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Date of inspection visit:

4, 5, and 6th August 2015

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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

Do not include in report

Requires improvement	
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

Do not include in report

We rated Whorlton Hall as Requires Improvement because:

- There was not an adequate assessment of the safety of the external environment. As a result, ~~The safety of the external environment had not been adequately assessed which meant~~ patients, staff and visitors ~~where~~ were placed ~~at~~ at unnecessary risk of harm.
- The layout of the hospital meant staff did not always have a clear line of sight of patients. ~~The hospital due to its layout did not have any clear lines of sight which meant patients could not always be overserved.~~ Where patients had clear plans in place regarding their observations, staff were not completing relevant documentation or carrying out observations in accordance with patients care plans.
- Ligature risk assessments were completed, but did not ~~had been completed, however they did not~~ contain any detail of how risks were mitigated. Patient records also did not record how possible risks were mitigated.
- The service did not use a recognised tool to establish staffing levels and dependency of patients. ~~We found~~ Tthere was not sufficient night staff to meet individual needs. We requested the provider send us a plan detailing how improvements would be made immediately.
- Mandatory training on~~in regards to~~ Mental Capacity Act, Mental Health Act and infection control was not adequate. ~~This put which placed~~ patients at risk of not having their rights upheld.
- The service used a low stimulus room without any protocols or procedures for its use and essentially secluded patients without proper processes in place.

Commented [[redacted]1]: Use of were mitigated twice – is there another way to word this so it reads a bit easier?

Commented [[redacted]2]: Do we put action we have taken in the summary? May be absolutely correct I just haven't seen it before?

Commented [[redacted]3]: Reads more like a judgement in the summary , maybe leave this out here?

- The service had its own risk assessment tool, however it was not being used in line with any formulated evidence based approach. Risk assessments were not regularly reviewed and agreed by the multi-disciplinary team.
- Medicine policies were out of date and there was no rapid tranquilisation policy. ~~despite it being used in the service.~~
- Patients did not always have health checks carried out in accordance with best practice.
- Positive behaviour support plans did not include information regarding communication, sensory, and proactive strategies to manage complex behaviours.
- There was limited assessment of patients communication needs across the hospital. ~~and S~~staff demonstrated ~~had~~ limited knowledge in developing models for patients using recognised tools to help improve both verbal and non-verbal vocabulary.
- No plans or treatment ~~was~~ were in place regarding sexuality and sexual behaviour, despite some patients having assessed needs in this area.
- The service did not use robust assessments and tools to plan and deliver care. ~~provide treatment and care in accordance with best practice because they did not use robust assessments and tools to plan and deliver care.~~
- The quality of reporting of multi-disciplinary meetings was poor. Recordings were not legible and ~~no~~ treatment plans were not formulated.
- The service did not meet the expectations of the Mental Capacity Act 2005. This had been identified ~~and despite identifying this~~ within an internal ~~the own organisations~~ audit, however no action had been taken to support staff until they had received training.
- Care plans were not person-centred because sufficient attention to patients communication needs had not been addressed.
- The hospital admitted ~~two~~ patients to an intensive support suite but no admission criteria was established.
- Patients did not have a discharge plan in place. No patients had a discharge plan in place despite one patient being in the process of moving to a different service.
- The service was not well- led. The service had not taken action in relation to identified areas in accordance with the organisations own monitoring systems.
- Staff training in mandatory areas was low and staff supervision and appraisal was an area for development.
- Staff lacked an ~~had a poor~~ understanding of the organisations vision and values.

However,

- Staff did report incidents of abuse
- Patients told us staff treated them with dignity and respect. ~~they felt respect by the staff and were treated with dignity and respect.~~
- Patients ~~were~~ engaged in weekly meetings where they could discuss their concerns or complaints
- Patients had ~~did have~~ access to advocacy
- Patients had ~~did have~~ access to leisure activities
- All patients had ~~did have~~ health action plans

Commented [[redacted]4]: There is a lot about how staff were lacking in the summary, just wondering whether this particular bit needs to be here or whether the first sentence says enough?

Commented [[redacted]5]: Is this too identifiable to this patient?

Commented [[redacted]6]: Bit wordy but doesn't say a lot? More specific?

Commented [[redacted]7]: As in they didn't attend or the training wasn't offered?

Commented [[redacted]8]: Again be more specific?

Requires Improvement

Whorlton Hall

Services we looked at

Wards for people with a learning disability or autism.

Contents

Summary of this inspection

Background to Whorlton Hall

Do not include in report

Whorlton Hall was registered from 3 September 2013. It had not previously been inspected ~~before~~. The hospital provides treatment and care for persons over the age of 18 who have a learning disability and/or autism. The service can accommodate up to 24 patients but ~~had~~ at the time of the inspection had reduced its beds to 19 patients.

At the time of the inspection, the service had seven patients within its care.

We spoke with four different government departments prior to the inspection and gained mixed views of the service. Some people described the service positively saying they were satisfied with the care provided whilst another stakeholder described the attitude of the service as "reminiscent of long term institutional care as provided prior to NHS Campus closure of the 1990's".

Commented [[redacted]9]: Not sure this goes in this section but could be wrong?

Our inspection team

Do not include in report

Our team included:

One lead inspector, two inspectors (in training), one inspection manager, one psychiatrist, one psychologist, one occupational therapist and one pharmacist and one expert by experience.

Commented [[redacted]10]: Make this a list, and feedback from my sqag was to clarify whether exe had lived experience or was a carer?

Why we carried out this inspection

Do not include in report

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

Do not include in report

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information, and sought feedback from patients.

During the inspection visit, the inspection team:

- visited and looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with the manager of the hospital and regional manager
- spoke with 12~~twelve~~ other staff, including the activities coordinator, a doctor, two healthcare support workers, three qualified nurses, an occupational therapist, and a psychology assistant.

We also:

- looked at seven treatment records of patients
- carried out a specific check of the medication management within the hospital
- looked at Mental Health Act (MHA) documentation to see if staff had followed the MHA Code of Practice
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

Do not include in report

Patients told us they were generally happy with the care and treatment provided at the hospital. Patients who were able to verbally communicate with us told us that staff treated them with dignity and respect, and described how staff would knock on bedroom doors prior to entering.

Where patients were unable to tell us their experience we observed staff interactions. ~~and found although staff~~ Staff spoke with patients in a kind and respectful manner they did not appreciate their learning and communication styles and therefore did not use aids to support patients despite ~~this being identified within their assessed needs.~~

We spoke with two patients relatives who also told us they were satisfied with the care provided. ~~However they also told us t~~They did not always feel fully included about decisions and were not kept informed of patient's progress. ~~often found themselves proactively contacting the hospital because staff working in the service did not make sufficient efforts to keep them informed of progress.~~

Commented [[redacted]11]: Long sentence, needs to be more concise

The five key questions we ask about services and what we found

We always ask the following five questions of services

Are services safe?

Requires Improvement

We rated safe as requires improvement because:

Commented [[redacted]12]: If you agreed with changes in the overall summary, make them here too.

- The safety of the external environment had not been adequately assessed which meant patients, staff and visitors where placed at unnecessary risk of harm.
- The hospital due to its layout did not have any clear lines of sight which meant patients could not always be overserved. Where patients had clear plans in place regarding their observations staff were not completing relevant documentation or carrying out observations in accordance with patients care plans.
- Ligature risk assessments had been completed. However, they did not contain any detail of how risks were managed. Patient records also did not record possible risks.
- The service did not use a recognised tool to establish staffing levels and dependency of patients. We found there was not sufficient night staff to meet individual needs. We requested the provider send us a plan detailing how improvements would be made.
- Mandatory training in regards to Mental Capacity Act, Mental Health Act and infection control was not adequate.

- The service used a low stimulus room without any protocols or procedures for its use and essentially secluded patients without proper processes being completed.
- The service had its own risk assessment tool; however, it was not being used in line with any formulated evidence based approach. Risk assessments were not regularly reviewed and agreed by the multi-disciplinary team.
- Medicine policies were out of date.
- There was no effective process in place to learn from incidents.

Are services effective? **Requires Improvement**

We rated effective as requires improvement because:

- None of the staff could tell us what treatment patients received except for medication.
- There were no psychological treatments provided to patients with offending behaviours.
- Patients did not always have health checks carried out in accordance with best practice.
- Positive behaviour support plans did not include information regarding communication, sensory, and proactive strategies to manage complex needs.
- Limited assessment of communication needs across the hospital and staff had limited knowledge in developing models for people using recognised tools.
- No plans were in place regarding sexuality and sexual behaviour despite some patients having assessed needs in this area.
- The service did not provide treatment and care in accordance with best practice.
- The quality of reporting of multi-disciplinary meetings was poor. Recording were not legible and no treatment plans were formulated.
- The service did not meet the expectations of the Mental Capacity Act 2005 and despite identifying this within the own organisations audit no action had been taken to support staff till they had received training.

Are services caring? **Requires Improvement**

We rated caring as requires improvement because:

- Care plans were not person-centred because sufficient attention to patients communication needs had not been addressed.
- Patients did tell us staff treated them with dignity and respect.
- Patients did attend weekly community meetings where they were able to express their views of the service.

Commented [[redacted]13]: Positives should be separated with 'However' and the start of a new bullet list, and this doesn't balance as 2 positive and 1 negative but RI?

Are services responsive to people's needs? **Requires Improvement**

We rated responsive as requires improvement because:

- The hospital admitted two patients to an intensive support suite but no admission criteria was established.
- No patients had a discharge plan in place despite one patient being in the process of moving to a different service.
- There was no evidenced based approach to analysing therapeutic based activities to ensure they were reflective of patient needs.

- Patient's communication needs should have been adequately assessed and staff should effectively support patients to enhance their abilities.
- The hospital ~~did~~ optimise~~d~~ patient recovery. Patients had access to lounge areas and leisure activities to support independence.
- Patients told us they knew how to complain. The service had only received one formal complaint from a patient in over a year.

Are services well-led? **Requires Improvement**

We rated well-led as requires improvement because:

- Staff were not fully aware of the organisations visions and values.
- Training in mandatory subjects was not adequate which placed patients at risk of not always having their rights upheld.
- Staff supervision was improving, although ~~although improving~~ was still not adequate.
- The governance system in place although it was comprehensive the service had still not actioned key areas identified.
- Staff did speak positively about the manager but described the overall staff morale as being "ok" with acknowledgement that it fluctuated.

Commented [[redacted]14]: No 'shoulds' in the summary

Commented [[redacted]15]: Again separate with 'however'

Commented [[redacted]16]: Needs re-wording. 'A governance system was in place' is this a positive as its worded like a negative?

Commented [[redacted]17]: All the potential positives here are worded negatively – need to decide if they are positive points and if so reflect them as such with more detail in the body of the report.

Detailed findings from this inspection

Do not include in report

Mental Health Act responsibilities

Staff had limited training in the Mental Health Act (MHA) and the Code of Practice with only 5% of staff having received training.

A ~~Mental Health Act Monitoring~~ MHA monitoring visit took place in January 2015 where it was established patients were detained correctly ~~under the Act,~~ and ~~they~~ had access to tribunals and managers meetings. ~~However it was identified patients~~ Patients were not regularly informed of their rights and information available to patients was not clearly displayed. During our visit one detained patient told us they were not always informed of their rights and was not provided with any information.

Noticeboards contained no ~~We found where information was displayed on notice boards there was no~~ information regarding patients' rights ~~displayed anywhere~~. We brought this to the manager's attention and this was ~~that~~ rectified ~~the issue~~ immediately.

Patients were able to have leave under section 17 of the MHA, and this was not cancelled due to staff shortages. ~~It was also established patients were facilitated with section 17 leave and this was no cancelled due to staffing shortages.~~

Do not include in report

Mental Capacity Act and Deprivation of Liberty Safeguards

An internal audit in June 2015 identified that the service ~~We were given a completed audit dated June 2015, which highlighted the service,~~ was not meeting the expectations or requirements of~~under~~ the Mental Capacity Act 2005 (MCA). ~~It stated that patients~~ The audit found that staff understanding of the MCA was limited. Patients were not effectively communicated with during the assessment and this affected any decision~~,~~ which had been made.

Three records were reviewed ~~We reviewed three records~~ which commented on a patients ability to make decisions regarding their care and treatment. ~~but as highlighted in the own providers report staff understanding was limited.~~ No communication aids had been used as part of the decision making process, and there was no formulated approach to assessing the patients capacity.

Eight staff we spoke to demonstrated a poor understanding of the Mental Capacity Act and the application of this.

The hospital had three patients ~~in total~~ who were subject to Deprivation of Liberty Safeguards, (DoLS) applications.

Patients with impaired capacity, their capacity to consent had been assessed without any formulated approach and without taking into account the . This had been documented in patient care records and was decision specific where necessary.

Commented [[redacted]18]: Needs another look, words missing

Detailed findings from this inspection

Overview of ratings

Do not include in report

Our ratings for this location are:

Do not include in report

Wards for people with learning disabilities or autism

Requires Improvement

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Requires Improvement

Are wards for people with learning disability or autism safe?

Requires Improvement

Safe and clean environment

Improvements to the safety of the environment were required. The external grounds to the environment posed many risks to staff, patients and visitors. For example there was a large skip within the hospital car park, which contained debris as well as long planks of wood with~~which had~~ large nails attached. No risk assessment was in place for the skip. ~~We asked to review the risk assessment in place for the skip but was informed by a senior manager that no risk assessment was in place.~~ Five of the ~~out of~~ seven patients had a history of assaulting others, which also included using objects as weapons. ~~The service had failed to grasp that a skip full of wood and nails could have potentially been used as weapons.~~ Patients had access to the ~~skip~~, and the service had failed to identify the potential risks involved.~~area in question~~.

~~We equally identified that other external areas such as~~ T~~t~~he garden area contained a substantial amount of broken glass, wood, nails and large rocks. Again, this was a potential area that patients could obtain material that could have been used to harm themselves and others.

~~There had been no audits evaluating the appropriateness of objects which could be a potential risk to those using the service as well as those visiting and working within the hospital.~~
We brought our immediate concerns to senior managers in the hospital and at our request the skip and garden debris was removed.

Commented [[redacted]19]: I think this is covered by saying there was no risk assessment?

~~We toured the hospital internally and found there was no clear lines of sight,~~ There were no clear lines of sight within the hospital, which meant patients could not be observed other than with staff presence in each patient area. ~~We found staff~~ Staff were not carrying out observations in accordance with individual risk assessments and the organisations observation policy dated April 2015. For example, two female patients were cared for in a separate area of the hospital where only staff could access with a key fob. ~~Throughout our inspection these~~ These patients

were left alone without any supervision despite one patient record detailing the patient required eyesight observations.

We carried out an unannounced night inspection on 5 August 2015 to observe how patients were cared for, and to ~~also~~ take the opportunity to speak with night staff. On our arrival, with the exception of one staff member who answered the door, all other members of staff were in the hospital kitchen area where they had been eating an evening meal. No members of staff were within patient areas despite some patients requiring one ~~-one~~to one ~~observation~~ and eyesight observation. We raised our immediate concerns with the nurse in charge ~~and expressed our concerns~~ that staff were not following the care plans of patients. We were told staff routinely ate together at an evening and then concentrated on cleaning duties. Three other staff stated that ~~We were equally told by the night nurse and two support staff that patient areas were not always occupied by staff~~staff did not always occupy patient areas, and that ~~. We were told~~ if patients left their room's door alarms were activated. We were told these alarms were not used as a method to observe patients but were used to support staff in their observations.

During our visit alarms were activated and we timed how long it took staff to deactivate the alarms. It took staff almost two minutes on one occasion. Within this time frame the patient concerned due to their needs and behaviour may have had the potential to have taken the opportunity to have harmed another patient. Incident records indicated a patient had been harmed by another patient before staff had responded to an alarm. ~~We saw incident records where this had occurred.~~ The patient concerned should have been within eyesight observations. Patient rooms did not have observation panels on the doors, making it difficult to maintain eyesight observation when a patient was in their room. No protocol was available to advise staff on how deal with this.

~~We noted a further patient who was also prescribed eyesight observations. However there was no protocol on how this was to be completed when patients were in their rooms given that no rooms had any window panes to enable to closely monitor patients.~~

We requested to review the observation records for patients on the evening of 5 August, however there were no records available. Staff told us they completed the records within patient notes at the end of their shift. This was contradictory to the organisation policy and equally placed patients and others at possible risk of harm because staff failed to observe patients in accordance with their risks and care plans.

A ligature risk assessment completed in July 2015 identified a number of concerns such as….. The response to each concern ~~We reviewed the ligature assessments which were in place both dated July 2015 and found although the service had carried out assessments and identified a number of concerns the response to each concern~~ was the risk was to be ~~"~~managed locally~~",~~ ~~However~~ however there ~~was~~ were no details within the assessment or within patient assessments as to how ~~this was happening. risks were being managed~~.

The service was clean and steps had been taken to minimise the risk of infection. The service employed domestic staff who were responsible for daily cleaning. There were cleaning schedules in place and ~~equally~~ audits to ensure the possible risk of infection was reduced~~minimised~~. One bathroom in an unoccupied area was dirty, and it was unclear when this had last been used. ~~We did however note that one space within the hospital that was not occupied or used required cleaning attention within the bathroom area. It was unclear when the bathroom was last used and equally when it was last cleaned.~~

Safe staffing

Commented [[redacted]20]: This doesn't make sense I don't think – aren't they the same?

Commented [[redacted]21]: Which alarms?

Commented [[redacted]22]: By responding or just pressing a button?

Commented [[redacted]23]: Not sure you should say this as it didn't actually happen?

Commented [[redacted]24]: Do you have any examples of what was on it?

Staffing levels in the service were not adequate. ~~Senior managers told us staffing~~ Staffing was assessed in accordance with NHS England Staff Guidance and ~~they~~ the service did not use any other types of dependency assessment tools. Night shift levels failed to meet the needs of patients effectively. For example, staffing had been set at five members of staff comprising of one nurse and four support workers. One patient required five members of staff to de-escalate an~~d~~ incident should they become distressed. We noted a serious incident occurred in the hospital during the month of May 2015 and only four members of staff were available. Records ~~also~~ indicated it took a considerable number of hours to make successful contact with the on-call person in charge, and the police needed to be called. ~~which resulted and contributed in police assistance~~.

No further consideration had been given that incidents did occur during the evening and if all members of staff were occupied in the de-escalation of an incident then no staff members would have been available to complete tasks such as observations as well as manage other patients who may equally become distressed.

Commented [25]: Long sentence, needs re-structuring.

Staff were engaged in cleaning activities, while patients who required eyesight observations were unattended.~~equally not effectively deployed in their duties we noted observations were not being carried out in accordance with patients' prescribed levels of observations and were engaged in other activities such as cleaning tasks~~.

Establishment levels: qualified nurses (WTE)	6
Establishment levels: nursing assistants (WTE)	27
Number of vacancies: qualified nurses (WTE)	3
Number of vacancies: nursing assistants (WTE)	3
The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in 3 month period	200
The number of shifts that have NOT been filled by bank or agency staff where there is sickness, absence or vacancies in 3 month period 0	0
Staff sickness rate (%) in 12 month period	17
Staff turnover rate (%) in 12 month period	25

There was also a staff vacancy in speech and language therapy. ~~also.~~ The manager reported the service had difficulty in recruiting staff due to it's location and poor transport links. A staff recruitment strategy was being implemented to look at new ways of attracting employees.

~~We were told by the hospital manager that staffing~~ Staffing levels during the day usually consisted of one qualified nurse and eight support staff or sometimes two qualified nurses and seven support staff. Staffing rotas ~~we looked at~~ confirmed ~~each shift had the required number of staff.what we had been told~~. The hospital manager ~~also told us that they~~ could request additional staff when patient needs dictated. ~~but the main difficulties the service encountered was recruiting staff due to the hospital location and poor public transport links. The manager told us this was a recognised issue throughout the organisation and a staff recruitment strategy was being implemented looking at ways to attract new employees.~~

The service did have records relating to mandatory training. We evaluated the records presented and noted that there was significant gaps in some areas. For example:

Commented [26]: You say they didn't keep records, but that you then looked at some? Might need to be a bit clearer?

- 10% of staff had completed training in Mental Capacity Act and deprivation of liberty safeguards.
- 5% of staff had received training in mental health.

- 36% of staff had received infection control.
- 77% of staff had received training in equality and diversity.

~~We were told this~~ This training was provided by e-learning through the Danshell Academy.

~~We did note where~~ Where training had been delivered as a group the attendance rate ~~then~~ it was significantly higher. For example areas such as:

- 100% of staff had completed managing violence and aggression
- 100% of staff had received first aid training.
- 98 % of staff had received training in safeguarding
- 93% of staff had completed training in positive behaviour support.

Assessing and managing risk to patients and staff

Staff told us ~~that~~ that the service did not have a seclusion room and this was something the service did not do. ~~However we did find that there was a~~ A designated room referred to as "room 10" ~~which~~ was presented to us as a low stimulus room. Patients were escorted to the room by staff and held in restraint on occasion unable to leave should they be in distress. The Mental Health Act Code of Practice defines seclusion as: "The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others."

The code of practice equally states:

~~It~~ Seclusion should not be used:

- as a punishment or a threat,
- as part of a treatment programme,
- because of a shortage of staff,
- where there is a risk of suicide or self-harm.

We looked at eight incident records where the use of the room had been used and brought our concerns to the attention of managers in that there was no policy or guidance in place for the use of the room and equally no appropriate safeguards to ensure the room was used for its intended use.

In the previous six months there had been 129 incidents of restrain involving ten patients.~~There were 129 incidents of restraint used in the last six months and these related to 10 different patients.~~ None of the restraints were in the prone position (prone position restraint is where a person is held face down).

We looked at the risk assessments of ~~completed in relation to~~ all seven patients~~'~~. The risk assessment tool used by the service was ~~referred to as~~ a "risk screening and assessment tool". ~~The tool~~ The Danshell group had developed the tool, and it had not been externally validated. ~~and was developed by the Danshell Group~~. ~~We reviewed the records of all seven patients and identified the~~It ~~tool~~ was not being used in accordance with the organisation's methodology, and nursing staff we spoke with had a poor understanding of its use.

~~For example risks~~ Risks were rated using a number system but it was unclear how the risk itself was being scored, as is was a subjective assessment based on nursing opinion rather than a formulated evidence based approach. There were gaps in ~~We also identified areas where patients had gaps in the~~ the risk recording and ~~also where~~ information was inconsistent. One patients records identified they presented no risks of inappropriate sexual behaviour, however

Commented [[redacted]27]: Be clear how you know this - Did staff or patients tell you this? Or did you witness it or see records?

Commented [[redacted]28]: Long sentence, consider re-wording?

Commented [[redacted]29]: Not sure about use of brackets? Also maybe clarify why whether they were in the prone position is an issue?

Commented [[redacted]30]: Maybe keep this paragraph with the one above?

Commented [[redacted]31]: No idea how to get round this but with only 7 patients does this make it possible to identify the patient? No idea how to balance that with the need for detail though!

details in the care records stated the patient had on a number of occasions attempted to intimately touch others.

~~We were also told by staff that risk~~ Risk ratings were not agreed by the multi-disciplinary team as this was a task completed by nurses. National Institute of Health and Care Excellence (NICE) (Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges) recommends that organisation's should consider using a formal rating scale such as Aberrant Behaviour Checklist or Adaptive Behaviour Scale. ~~which~~ This would provide baseline levels for patient's ~~the~~ behaviour and a scale such as the Functional Analysis Screening Tool to help understand its function. The service did not use any of these tools.

We also noted that risk assessments were reviewed on a six monthly basis or where a patients increased needs had occurred. We expressed our concerns regarding the absence of regular reviews of risk management plans.

Commented [[redacted]32]: How often should they be reviewed? Just thinking in a number of services its six monthly or when something changes?

There were restrictions in place for patients. Staff demonstrated little understanding of autism, communication needs and recognised best practice. This contributed to a limited understanding of individual needs, and as a result, there were high levels of restraint and restrictive practice to manage difficult and complex behaviour. ~~There was a high use of restraint to manage difficult and complex behaviours and staff had limited understanding of autism, communication and recognised best practices all of which contributed to limited understanding of individual needs resulting in restrictive practice within the service.~~

Commented [[redacted]33]: What were they?

The service managed medicines correctly. ~~Medicines were managed correctly.~~ The clinic was tidy, and worktops were clear of any objects or paperwork. ~~Each patient had their~~ Patients had their own medicine basket labelled. The drug cupboard was suitable for the number of patients present and medicines were stored away safely and correctly. There was no excess medication or over storage of medication. The medicines were ordered from the GP as per medicines management policy, and copies of the prescriptions were stored away in a ~~the~~ folder.

On inspection of all drug cards they were legally compliant, legible and in accordance with the Human Medicines Regulation act 2012. No missed signatures were noted by nurses administration in the drug cards.

Commented [[redacted]34]: Are they called something else? Like prescription charts or medication administration records?

Care plans were written in detail ~~Where~~ where patients required medication on an "as and when required basis". ~~care plans were written in detail,~~ Medication used for rapid tranquilisation was not reviewed for all patients. ~~however where medication was used for rapid tranquilisation there was no evidence that this medication had been reviewed for all patients.~~ The service was not following the NICE ~~National Institute of Health and Care Excellence~~ guidelines (NG10) Violence and Aggression point 1.3.11.

~~Although evidence~~ Evidence was present in the multi-disciplinary team notes that "as and when required" medication ~~has~~ had been reviewed by the patient's doctor, but it was not in line with the above recommendation. Moreover, "as and when required" medication for rapid tranquilisation had not been utilised by some patients but was still present on drug cards. Overall, where "as and when" required medication either psychotropic or physical health was not used it had not been reviewed and stopped where appropriate.

The organisation did not have any policy relating to rapid tranquilisation. ~~and therefore~~ This meant nurses had been administering drugs without any organisational guidance on the appropriate use.

Nurses completed medicines management audits annually, with the most recent on 30 June 2015. The last three we reviewed were: ~~There was evidence that audits relating to medicines management were done by nursing staff. We inspected the three audits, which were completed on 30 June 2015 and done annually; they were Medicines~~ medicines management, "as and when required" medication and ~~Controlled~~ controlled drugs. Nursing staff did not engage with any Prescribing Observatory for Mental Health UK audit.

The medicines management policy was due for review in July 2015, and was therefore out of date. ~~We found medicine management policy needed reviewing as the review date on the policy was July 15.~~ The ~~medicines management~~ policy ~~also states~~ stated that two nurses ~~are~~ were to sign for the administration of controlled drugs however, the service is often operating only one nurse per shift.

Staff told us that ~~From interviewing, one nurse we were told~~ a pharmacist only visited the service once a year and did not participate in multi-disciplinary team meetings. If patients wanted to discuss medication, they would do so with the nurses, doctor or their GP.

The service did not have any lifesaving medicines on the premises. Staff had not received training in the administering of life saving medications and would call the emergency services if required. ~~enior staff told us that it was not the organisations policy as staff would be expected to call emergency services and equally staff had not received any training in the administration of life saving medications.~~ However, emergency lifesaving equipment was available and was tested daily to ensure it suitability for use should an ~~emergency situation~~emergency arise.

There were records, which had been completed on a daily basis to demonstrate equipment was safe.

Arrangements for protecting patients from abuse were in place. Staff knew how to raise concerns and report incidents. ~~All staff we spoke with were able to inform us how they raised concerns and reported incidents. We did find that patients~~ Patients had accused staff of bullying and using inappropriate behaviour. Where patients had a known history of making allegations there were care plans in place with clear protocols for staff to follow. However, where patients abused each other through violence or aggression the service had limited information available to discuss rules about behaviour and expectations towards others. Although the service did provide some details in "easy read" this did not support the individual communication styles of all patients. ~~some patients who were not given information that best supported their own individual communication styles.~~ Patients ~~we spoke with~~ were unsure ~~when we talked to them~~ how they would protect themselves from abuse.

Track record on safety

Reporting incidents and learning from when things go wrong

~~Staff told us that incidents~~ Incidents were reported on the RIVO system. We reviewed 17 incident records on the system and found they were detailed in their recording giving full details of the incident and what actions staff had taken in response to the incidents.

The service had a method of collating the incident records and producing graphs to show any theme or trends, however seven staff we spoke with during the inspection told us that incidents were rarely shared between the team other than at staff handovers or where the manager had informed them. Staff told us there was no formal process for reflective practice.

Commented [[redacted]35]: May need to explain this as I don't know what it is/means?

Commented [[redacted]36]: What equipment?

Commented [[redacted]37]: Long sentence?

We viewed medication errors within the service on the internal reporting system RIVO. There were three medication errors reported from August 2014 to present. We discussed with a senior nurse the learning from errors and were told that the clinical governance department was in touch with services to share information. There was no reflective tools used post error for nursing staff as a way to improve practice or learn from the error. Reflection post incident is seen as an exceptional way of learning.

Two patients told us they enjoyed the community meetings but did not always feel listened to when raising concerns about staff attitude towards them. Patients had made three allegations about staff ~~There had been three allegations against staff where patients had made accusations regarding~~ conduct and behaviour. ~~Equally, external~~ External organisations had also made accusations regarding staff conduct and behaviour ~~within the service~~ but these were not substantiated following internal investigations by the service. We asked the service to provide us with information detailing the number of allegations made against staff regarding poor attitudes but the service had not provided this information .~~investigations by the service had not substantiated any of the incidents.~~ There was no evidence that ~~We equally found no~~ learning from these incidents had taken place.

~~We asked the service to provide us with information detailing the number of allegations made against staff regarding poor attitudes but the service had not provided this information despite our request.~~

Commented [[redacted]38]: Give date as not present now

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Are wards for people with learning disability or autism effective?

Requires Improvement

Assessment of needs and planning of care

Assessments were not comprehensive, holistic or person- centred. There was an overall lack of formulation and functional assessments as well as any use of applied behaviour analysis.

Patients did ~~r~~ have health action plans and physical health care checks. Although we did find where patients were prescribed routine antipsychotic medication relevant checks had not always been carried out. For example, one patients ~~-~~last ECG was done on 4 November 2013. In accordance with ~~It should be done annually especially when taking antipsychotics this is in accordance with~~ Mawdsley prescribing guidelines 2014 this should be completed annually. We also noted that the last blood tests for one patient were done 18 June 2014 and again this should be done annually.

Evidence of weight monitoring and blood pressure were present and were regularly ~~been~~ being done. With view of side effect monitoring of formal tools (GASS/LUNSERS) or validated tools in learning disability services were used to capture this information but it was left to nurses observations of side effects with patients. It is encouraged that side effects are discussed with patients and tools are used to capture this information. There was no evidence this occurred and equally care plans did not contain any details regarding the side effects of medication and what nursing staff are required to observe.

Care model was that of personal PATHS.

All seven care plans lacked a treatment plan or discharge plan. Staff spoke of positive behaviour support and activities, but were unable to clarify what treatment was being provided other than

Commented [[redacted]39]: Give full definition

Commented [[redacted]40]: Doesn't make sense?

Commented [[redacted]41]: Will you be saying more about this?

medication. ~~We reviewed all seven care plans none of them detailed a treatment plan, equally none of the staff we spoke with including senior managers were able to tell us what treatment was provided in the hospital other than medication. All staff we spoke with discussed positive behaviour support and activities. All care plans lacked an overall approach to treatment and discharge.~~ Other areas we identified were:

- Positive behaviour support plans of each patient did not contain information that is pertinent to the principles of positive behaviour support. Details of patients communication styles, sensory needs and specific behaviours and triggers were not incorporated within individual plans as well as details of how staff were to manage challenging and complex behaviour. Plans were written in a format~~,~~ which was reactive to patient behaviour as opposed to preventative.

- There was limited assessments and planning of communication needs across the hospital. Where patients had communication assessments in place staff failed to follow the plans and support patients effectively. One patient's preferred method of communication was the use of "talking ma~~t~~ts". The patient had no talking mats available to use and staff had received no training in their use. Two staff we spoke with failed to understand and grasp the importance of the use of communication methods. We were told for one patient that they did not use the patients preferred methods because "they wanted them to speak". There was no understanding that in order to support a patient effectively the fundamental basis should be to understand their way of communicating, and support them to widen and develop their vocabulary in a language that is comfortable to them.

- One patient who had autism had no communication plan in place despite limited vocabulary. A model of communication is essential for any effective treatment and care for a patient with autism.

- A visual timetable was in use for a ~~nother~~ patient with autism ~~had a visual timetable but this~~ This was poorly structured and did not use the individual's identified communication tools. ~~layout for example the patient communication tools were talking mats but a visual timetable was not presented in this way.~~

- One patient knew ~~despite knowing~~ Makaton signs, however they ~~were~~ not used. Staff stated ~~told us~~ "If we use Makaton all the time he won't get any better".

- Patients did not have ~~No patients had~~ any care or treatment plans in place addressing sexual behaviour and relationships despite some patients having identified needs in this area.

- One patient had engaged in cognitive behavioural therapy to address some behaviours that required management. ~~However the~~ The strategies that had been developed were not incorporated into any care plan and there was no ongoing ~~working to~~ support ~~the patient~~ to maintain positive behaviours such as reflective work. Staff could not evidence ~~All the staff we spoke with during our inspection were not able to inform us~~ how the cognitive behaviour therapy was being used to support the patient in their care and treatment.

Commented [[redacted]42]: Long sentence

- One patient had concerns regarding their oral healthcare but staff had not received any training in this and ~~to support the patient and equally~~ there was limited detail in the patients care plan on how the person was to be supported.

~~We were told by staff and senior managers that they~~ Staff could make referrals to the in-house speech and language therapist as the North East had a vacant post, but response time was slow and there was no active involvement due to the services location.

Best practice in treatment and care

The service did not follow best practice and guidance in regards to the care and treatment for patients with a learning disability and/or autism.

However the service did use Health of the Nation Outcome Scales for People with Learning Disabilities, Health Equality Framework.

Skilled staff to deliver care

Staff were not skilled to deliver effective care to patients. The service had a focus on positive behaviour support but ~~yet~~ there was no oversight or scrutiny of staff understanding to ensure it was implemented effectively. Staff had received training in positive behaviour support, however they only received this training once and there was no refresher training or steering groups set up to ensure staff worked in a consistent and collaborative manner.

One staff member had completed a course at York college in communication, and two staff had completed level two in British sign language. ~~Also~~ A further two staff ~~we spoke with during the inspection~~ had completed some training in Makaton, which is~~.~~ a form of sign language. ~~(A form of sign language).~~ Despite this ~~However despite some staff having received training~~ the service did not use any ~~used no~~ effective communication models. Communication models ~~to~~ support patients to develop and enhance their vocabulary. This ~~ensures~~ensuring their needs are ~~could be~~ understood and met as well as ensuring treatment ~~was~~ is safe and effective. Staff demonstrated limited understanding of the importance of effective communication in both treatment and care. They did recognise this as an area for improvement. ~~although they recognised it was an area that required significant work.~~

Staff had not received training in supporting people with mental health problems, despite patients having a diagnosed mental illness./disorder?~~None of the staff we spoke with during the inspection had received any training in mental health despite two patients having mental health conditions such as anxiety and mood disorders and emotional unstable personality disorders~~. Care records of ~~we reviewed in relation to~~ patients with mental health difficulties did not have any treatment plans, strategies or interventions on how to support, care and treat the patient.

Staff had not received any specialist training in autism despite some patients having a diagnosis. We were told by one senior staff member that training was intended when one person commenced a discharge pathway. However no training had been implemented to ensure staff were able to effectively support the patient through their care end treatment ensuring their length of stay was to a minimum and high quality care provided.

All clinical staff confirmed they had ~~clinical~~ at least six clinical supervisions a year and an annual appraisal. ~~However staff supervision required improvement~~. Records provided showed…. Had

Commented [[redacted]43]: Sorry I don't fully understand – is there one patient with autism and they are being discharged so staff haven't bothered with training?

received supervision and appraisal. One member of staff told us they had received no supervision for over a year and a half.

Multi-disciplinary and inter-agency team work

Patients were invited to ~~The service had~~ weekly multidisciplinary team meetings. ~~Patients were invited to meetings and attended where they wished.~~ We saw instances where patients had raised issues such as length of time it took for discharge and clarification regarding what alternative placements ~~were~~ being sought.

~~Multi-disciplinary meetings were made up of~~ These involved a doctor, nurse, support workers and other allied health professionals such as occupational therapist and psychologist. We did note however that allied professionals such as occupational therapist and psychology had limited input to the service due to time allocation. Occupational therapy and psychology consisted of one and a half days. We were told by the professionals themselves they were restricted with the level of support they could offer due to limited time and resource.

The quality of the written multi-disciplinary notes review were poor because they were not easily legible and very brief. There was also no clear summary of therapeutic plan, no clear formulation, diagnosis or ~~and~~ treatment plan

There was equally no evidence of how clinical audits carried out influenced overall clinical practice.

The service did invite external agencies to the multi-disciplinary meetings, such as commissioners. ~~attempt to involve other agencies such as commissioners by inviting them too monthly multi-disciplinary meetings but they~~ They often did not attend and subsequently did not contribute to the meetings but were sent the minutes.

We observed one handover process. It was structured in a way that described the patients daily activity rather than risk focus considering the patients levels of risk and changing needs.

The service had built working relationships with the local GP practice. Patients did have health action plans in place and it was evident where a person required medical care, appointments had been made with other professionals and treatment received.

Adherence to the MHA and the MHA Code of Practice

Staff had limited training in the Mental Health Act and the Code of Practice with only 5% of staff having received training.

A Mental Health Act Monitoring visit took place in January 2015 where it was established patients were detained correctly under the Act, they had access to tribunals and managers meetings. However it was identified patients were not regularly informed of their rights and information available to patients was not clearly displayed. During our visit one detained patient told us they were not always informed of their rights and was not provided with any information.

We found where information was displayed on notice boards there was no information regarding patients' rights displayed anywhere. We brought this to the manager's attention that rectified the issue immediately.

Commented [[redacted]44]: The 'so what' question?

Commented [[redacted]45]: Follow this sentence on from the first one in the first paragraph?

Commented [[redacted]46]: Were there any audits? If so what and what was missing?

Commented [[redacted]47]: Doesn't read correctly?

Commented [[redacted]48]: Again if you agree with changes at the start of the report make them here

It was also established patients were facilitated with section 17 leave and this was no cancelled due to staffing shortages.

Good practice in applying the MCA

We were given a completed audit dated June 2015, which highlighted the service, was not meeting the expectations or requirements under the Mental Capacity Act 2005. It stated that patients were not effectively communicated with during the assessment and this affected any decision, which had been made.

We reviewed three records which commented on a patients ability to make decisions regarding their care and treatment but as highlighted in the own providers report staff understanding was limited. No communication aids had been used as part of the decision making process, and there was no formulated approach to assessing the patients capacity.

Eight staff we spoke to demonstrated a poor understanding of the Mental Capacity Act and the application of this.

The hospital had three patients in total who were subject to Deprivation of Liberty Safeguards, (DoLS) applications.

Patients with impaired capacity, their capacity to consent had been assessed without any formulated approach and without taking into account the . This had been documented in patient care records and was decision specific where necessary.

Are wards for people with learning disability or autism caring?

Requires Improvement

Kindness, dignity, respect and support

On the 4 August 2015 the provider was given an opportunity to do a presentation on the services provided at Whorlton Hall. Staff at Whorlton Hall decided to include patients as part of the presentation. During the presentation, one patient was given a script to read when their reading skills were clearly very limited as was their communication in general. This resulted in a humiliating exercise that was embarrassing for all concerned. Senior managers and staff did not demonstrate any skills to be able to turn this around with knowledge of how to engage the patient in conversation or how to work alongside him. A senior manager acknowledged what happened was both embarrassing and inexcusable.

We spoke with four patients during our inspection and our expert by experience participated in one activity with patients to understand their experience further.

~~Observations of patient care we found staff~~ Staff spoke to patients in a kind and dignified manner and offered support and direction where needed. We observed one incident during the inspection where a patient became distressed. Staff supported the patient by in a compassionate and caring manner offering reassurance to minimise the distress being presented.

Patients told us that staff knocked on their doors prior to entering rooms and that they took time to listen and explain things to them when they required additional support.~~.~~

The involvement of people in the care they receive

-The service had not addressed the communication needs of its patients adequately. People did not have detailed plans in place that would enable staff to follow key principles that focused on each patient's communication styles and methods to ensure care was holistic and personalised.

The service had attempted to complete some person-centred plans ~~however,~~however; these were incomplete for almost all patients and had little focus on increasing skill and independence. Plans had not been developed in line with how patients communicated other than some easy read templates, which was not suitable for all patients. The service ~~appeared assured by its easy read material because they~~ had won awards for their easy read material, but a senior manager acknowledged the material was not reflective of the needs of all patients.. ~~However, much of the material was not reflective of the needs of the patients at the service and this was acknowledged by a senior manager.~~

The service held ~~did have~~ weekly meeting with patients where they could discuss a range of issues that affected them. One patient told us they had used the meetings to highlight concerns regarding some maintence work however, the issues remained outstanding, as action had not been taken.

Commented [[redacted]49]: What awards? Would it be a separate positive point?

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

Requires Improvement

Access and discharge

Pre-admission and admission assessments, risk assessments and positive behaviour support plans care plans did not clearly link up (other than the use of "copy and paste" text)

Patients who were admitted to the hospital were referred generally within the North East area although the hospital did have capacity to take patients from other parts of the country.

On admission to the service patients underwent a 12 week assessment process to identify their needs. This is considered a lengthy process and does not reflect best practice in regards to ensuring that patients receive treatment in hospital for the minimum time possible.

The service also had what they referred to as an intensive support suite which could accommodate three patients within the hospital. There were two patients that occupied this area during our visit. There was no admission criteria for the use of the suite and ~~equally there was~~ no protocol on what patients needed to achieve in order to move out of the suite. We were told it was a service that provided intensive support but staff and managers were not able to articulate how this differed from any other service or treatment that was being provided.

The average length of stay was 2.1 years. Recently some patients had been discharged that had been accommodated as long as 14 years. ~~The service had prior~~ to our visit discharged some patients that had been accommodated as long as 14 years.

In line with recommendations from the Winterbourne View Report, Transforming Care; Department of Health 2012 the service had made a reduction in its beds by reducing from 24 beds to 19. We were told the hospital was in the process of considering other ventures for its use but had not established a clear vision as of yet.

Commented [[redacted]50]: Word differently – some documents appeared to be standardised as elements were repeated across patients care records!

Commented [[redacted]51]: Do you know how many?

Patients did not have a discharge plan in place, and senior managers recognised this as an area for development. ~~We looked at the discharge arrangements in place for each patient and found none patient had a plan in place, senior managers recognised this was an area which required improvement.~~

The hospital reported that there had been one delayed discharge between 1 February 2015 and 1 August 2015.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital was spacious with a variety of areas that patients could be engaged in activities. Patients appeared to regularly use a lounge area with facilities to watch TV and play pool. ~~For example the service had a lounge area with TV and pool table. We observed throughout our inspection patients using this facility.~~

The service had also developed a~~n~~ computer suite, however this was not up and running during our inspection and was still within its infancy. ~~However patients~~ Patients did tell us they had ~~did have~~ access to computers with staff support.

Patients also had access to mobile phones as well as phones within the service. Patients told us there were no restrictions in place for the use of phones and could use them when they requested.

The service provided care and treatment to three patients with sensory impairments and one patient with mobility issues., ~~however there was no~~ No environmental assessments were in place to demonstrate the patient's needs had been taken into account.

Records were stored securely in the office environment and this ensured patient confidentiality ~~to patients~~ was maintained.

The care plan of one patient identified a risk assessment should be completed prior to any outing in the community. This patient was taken into the community on the morning of our visit, and staff were unaware of the need for a risk assessment. They did not follow the care plan, which was in place to ensure patients received safe and appropriate care. ~~senior members of staff we spoke with were unable to tell us the specific care plan relating to arrangements for taking one patient out into the community despite the care plan stating a risk assessment should be completed prior to each outing.~~

~~We spoke with two staff member who had been supporting the patient on the morning of 5 August 2015 and they were unaware of the plan's existence, or the procedures which should be followed. This demonstrated staff did not follow the guidelines, which were in place for patients which were essentially there to ensure patients received safe and appropriate care.~~

~~We saw examples of where strategies~~ Strategies and interventions had been provided by health professionals from other organisations relating to the management of sexualised behaviour and effective communication. None of the advice provided had been incorporated into a care plan and when we spoke with staff they were unable to tell us about the guidance provided or the strategies or interventions that should be used. This meant that important information for the care and well-being of people was not being followed.

The Department of Health Guidance Positive and Proactive Care: reducing the need for restrictive interventions clearly sets out what the expectations are for caring and managing

Commented [[redacted]52]: Link this with the paragraph that talks about average length of stay

Commented [[redacted]53]: Do you know why? Again link with above I think.

Commented [[redacted]54]: wording

people who have complex behaviours. Within the guidance it is detailed how services such as Whorlton Hall should incorporate positive behaviour support and the use of functional assessments as a core value for supporting people. The service did not incorporate elements of the guidance.

The NICE Guideline in relation to Autism is directly relevant to the services provided at Whorlton Hall and this was not embedded within the service and there was little or no regard for them at all. When we spoke with a senior manager we were told that no audits had been carried out against the guidance to ensure the service was being responsive to patient needs.

Commented [55]: is this in the wrong section?

Meeting the needs of all people who use the service

There was evidence of occupational therapy input which was based on a human occupational model(MOHO). There were also sensory profiles which were a standardised assessment. However despite these approaches being adopted by the service there was no information to demonstrate how these assessments were incorporated into their daily lives and activities of patients and the review mechanisms for this.

Commented [56]: Long sentence

We spoke with two members of staff who had responsibility for activity co-ordinating. Neither ~~of them~~ had received training in a human occupational model and were not aware of what it was or how such a model was implemented.

We looked at the activity records for each patient and found they engaged in a range of activities such as going to the shops, going for walks, horse riding, cooking and other leisure activities. There was no format for establishing the therapeutic outcome or gain for the activities patients engaged in. Where patients chose not to engage in activities there were no intervention or strategies in place to train patients in the areas of need.

Commented [57]: Unclear what you are saying – doesn't read easy.

We observed a cooking session delivered by the hospital chef. ~~one cooking session taking place. The session was being ran by the hospital chef.~~ We found there was no structure to the session, instructions to patients participating were unclear and there was no clear direction been given. The staff member concerned had not received any training in delivering sessions to patients with complex needs and ~~there for~~ lacked the overall skills required. However we did note the staff member treated patients with kindness and did make a significant effort to support patients.

Commented [58]: Obviously this clearly identifies the staff member – is this ok?

We saw information relating to advocacy services on patient information boards and saw evidence of advocacy referrals in care records.

Care plans ~~equally~~ noted patients religious preferences and any dietary requirements they had such as vegetarian, but there was no focus on sexuality and relationships.

We found patients were offered a range of food choices during meal times. ~~and these~~ These were presented in picture format so patients who had limited verbal communication were able to express their choices effectively to staff.

Listening to and learning from concerns and complaints

The service informed us they had received only one formal complaint within 12 months. We did find that there was information displayed around the hospital on notice boards informing patients how they could make a complaint. Four patients we spoke with told us they would speak with staff or use the community meetings to raise any concerns or complaints they had regarding the service.

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

Requires Improvement

Vision and values

Staff ~~Woking in the service~~ with the exception of~~to~~ senior managers knew what ~~were able to inform us what~~ the organisations vision and values were. The service had created their own version of vision and values and this was displayed on a wall, but this was not a clear interpretation of the organisations vision and values.

The organisation had ~~did have~~ a quality strategy with a 16 point improvement intervention plan to be completed at a local level. ~~We saw team~~ Team meeting minutes ~~which~~ showed staff were informed of the quality strategy.

The unit led clinical governance committee and regional clinical governance framework monitored progress on the quality strategy. The minutes of the meeting asked if units had reviewed and updated their Unit Transformation (Quality Strategy) Schedule~~-~~. The minutes confirmed that Whorlton Hall management team still had not taken any action.

Good governance

The hospital was overseen by a clear governance structure operated by the Danshell group, which include~~d~~s an internal assurance system called quality development reviews.

The hospital ~~is~~ wassubject to a corporate audit programme, and we saw recent audit findings from a Mental Health Act audit, a safer restrictive physical intervention and therapeutic holding audit and a deprivation of liberty safeguards ~~DOLS~~ audit.

- All three ~~these~~ audits fell short of the organisations pass rate and actions had been set.
- We saw a recent infection control audit which had achieved the required pass rate.
- The service ~~prepares~~ prepared monthly internal service reviews which ~~are~~ werediscussed with the senior governance team and ~~includes~~included:

    - key financial issues
    - operational challenges
    - clinical issues
    - staffing issues and recruitment
    - governance

- occupancy
- incidents and risks
- staff training
- patient or commissioner issues

We saw an outstanding action to complete an environmental ligature risk assessment from ~~in these service reviews since~~ February 2015~~.~~ The assessment was completed in July 2015.

A clinical governance framework ~~uses~~ used information to monitor and manage quality and performance and we saw actions within minutes of improvement items to be achieved.

Commented [59]: Were they achieved?

The unit had a risk register with clear actions in place to reduce risks occurring.

We were told of the process for ensuring all staff attended mandatory training and staff were able to tell us what they were still due to complete. Compliance with mandatory training was poor in some areas, such as mental capacity act and mental health act. ~~was overall poor.~~

Leadership, morale and staff engagement

Staff reported the hospital manager was accessible and provided good support. ~~There was evidence of leadership at a local level with all staff interviewed reporting the unit manager was accessible and provided good support.~~

Staff described morale as "OK" "fluctuates" and "getting better". They felt able to speak up and ~~told us they~~ would go to higher senior management if the need ever arose.

Minutes were available ~~Bi~~from bi-monthly staff team meetings which showed ~~are held and we reviewed minutes and saw~~ a wide range of items were discussed. We saw areas for improvement from service reviews and incidents shared with staff, particular patient issues and reflections on care and progress on staffing issues such as recruitment and training discussed.

Staff told us they felt safe at work and that the team ~~works~~ worked well together. We saw assessments of risk which ensured staff worked in pairs with some service users, however this was not always being followed. Staff carried personal alarms and we witnessed responses to alarms during our visit.

- The average sickness rate was 12%
- Supervision and appraisals compliance was…..

At the time of our inspection there were no grievance procedures being pursued within the team, and there were no allegations of bullying or harassment.

Areas for improvement

Areas for improvement

Do not include in report

Action the provider MUST take to improve

Do not include in report

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	