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:

- Tthe hospital had not assessed the outside areas, which contained objects that could pose a risk to patients, staff and visitors.
- Tthe hospital layout meant that without a member of staff present in each area, they had no clear line of sight to observe patients.
- Where patients had care plans regarding their observations, staff did not complete relevant documentation or carry out observations in accordance with patients assessed needs.
- The hospital completed ligature risk assessments but these did not detail how to mitigate the risks.
- Ppatient records did not record how possible risks were minimised.
- Tthe service did not use a recognised tool to establish staffing levels and dependency of patients.
- Tthere were not enough night staff to meet individual needs.
- The service did not provide adequate mandatory training on the Mental Capacity Act or, the Mental Health Act, ~~which put patients at risk because~~to ensure ~~their~~ patient's rights ~~may not~~would be ~~-~~upheld.
- Tthe service used a low stimulus room without any protocols or procedures for its use.
- ~~a~~Although the service had its own risk assessment tool, they did not use it in line with any formulated evidence based approach.

- Tthe multidisciplinary team did not review or agree on risk assessments.
- Mmedicine policies were out of date and there was no rapid tranquilisation policy.
- Patients did not always have health checks carried out in accordance with best practice where they were prescribed antipsychotic medication..
- Ppositive behaviour support plans did not include information about patients' communication or sensory needs, or proactive strategies to manage any complex behaviours.
- Sstaff ~~across the hospital showed~~had limited understanding of patients' communication needs and assessment was limited.
- Patients did not have plans or treatment to address sexuality and sexual behaviour~~,~~ despite some patients having assessed needs in this area.
- The quality of reporting of multidisciplinary meetings was poor because they did not record whether staff formulated treatment plans.
- Although the service identified that it did not meet the expectations of the Mental Capacity Act 2005 during an internal audit, they took no action to support staff before they received training.
- ~~the~~ The hospital had no established criteria for admitting patients to their intensive support suite.
- Patients did not have a discharge plan~~,~~ despite patients being in the process of moving between services.
- Although the service conducted audits and held discussions, they were slow to act and recorded this as a risk to the hospital. Staff supervision and appraisal was an area for development.
- Staff did not know or understand the vision and values of the organisation.

However:

- Staff ~~did~~ reported incidents of abuse.
- The service knew about its responsibilities under duty of candour and where they identified mistakes they apologised.
- Patients told us staff treated them with dignity and respect.
- Patients engaged in weekly meetings where they could discuss their concerns or complaints.
- Patients had access to advocacy.
- The service had ~~included~~ involved families.
- Patients had access to leisure activities.
- All patients had health action plans.
- Patients ~~did~~ attended weekly community meetings where they were able to express their views of the service.

Commented [[redacted]1]: Which best practice?

Commented [[redacted]]: Was this about the recoding of MDTs, formulation of treatment plans or reporting to others?

Commented [[redacted]3]: Are there two issues here – action following audit and staff supervision? The audit statement isn't clear

Requires Improvement

Whorlton Hall

Contents

Summary of this inspection

Background to Whorlton Hall

Do not include in report

Whorlton Hall was registered on 3 September 2013. This was the first inspection. 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 at the time of the inspection reduced its beds to 19 patients.

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

Our inspection team

Do not include in report

Our team included:

- Oone lead inspector.
- Ttwo inspectors (in training).
- Oone inspection manager.
- Oone psychiatrist.
- Oone psychologist.
- Oone occupational therapist.
- Oone pharmacist.
- Oone expert by experience. (A person with a learning disability and their support worker).

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:

- Vvisited and looked at the quality of the hospital environment and observed how staff were caring for patients.
- Sspoke with four patients who were using the service.
- Sspoke with the manager of the hospital and regional manager.
- Sspoke with 14 staff, including the activities coordinator, a doctor, two healthcare support workers, three qualified nurses, an occupational therapist, and a psychology assistant.

We also:

- Llooked at seven treatment records of patients.
- Ccarried out a specific check of the medication management within the hospital.
- Llooked at Mental Health Act (MHA) documentation to see if staff had followed the MHA Code of Practice.
- Llooked 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. Patients who could verbally communicate with us told us staff treated them with dignity and respect., ~~and described how staff knocked on bedroom doors before entering.~~

Where patients could not tell us about their experience, we observed staff interactions. Staff spoke with patients in a kind and respectful manner but they did not appreciate their learning and communication styles. Although patient assessments identified their communication needs, staff did not use aids to support them.

We spoke with two relatives who told us they were satisfied with the care provided. However, they did not always feel fully included in decisions and told us staff did not keep them informed of their relative's progress.

We spoke with four different government departments before the inspection and heard mixed views about 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]4]: Family inclusion was highlighted as a good point above so conflicts with this statement.

Commented [[redacted]5]: This doesn't tell me who they were

Commented [[redacted]6]: I don't think this is an appropriate statement to put in a report, if the hospital was indeed like this then this would need to be collaborated – it reads like hearsay in this context.

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:

- 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 layout of the hospital meant there were no clear lines of sight., ~~so sS~~taff ~~meant staff~~ could not observe patients while outside patient areas.
- Staff were not completing relevant documentation or carrying out observations in accordance with patients assessed needs and care plans. ~~Where patients had care plans in place regarding their observations staff were not completing relevant documentation or carrying out observations in accordance with patients assessed needs~~.

- Ligature risk assessments had been completed but ~~. However,~~ they did not contain any detail of how risks were managed. Patient records ~~also~~ did not record ~~possible~~ any ligature risks or management.
- The service did not use a recognised tool to establish staffing levels and dependency of patients. There was not sufficient night staff to meet individual needs.
- 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~~ used seclusion without proper processes followed.
- The service had its own risk assessment tool~~; however, it~~ but this was not being used in line with any formulated evidence based approach. Risk assessments were not regularly reviewed and agreed by the multidisciplinary team.
- Medicine policies were out of date.
- The service did not have an effective process to learn from incidents.

However

- The service was aware of its responsibilities under duty of candour and where mistakes had been identified, apologies were made.

Commented [[redacted]7]: Is this what we mean?

Commented [[redacted]8]: This needs clarification (it might be done later)

Are services effective? **Requires Improvement**

We rated effective as requires improvement because:

- None of the staff could tell us what treatment patients received, apart from medication.
- There were no psychological treatments provided to patients with offending behaviours.
- Patients did not always have health checks carried according to best practice.
- Positive behaviour support plans did not include information regarding communication, sensory, and proactive strategies to manage complex needs.
- Staff had l~~L~~imited knowledge of assessment of communication needs ~~across the hospital and staff had limited knowledge in~~ and 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 or care according to best practice.
- The quality of reporting of multidisciplinary meetings was poor. Recordings were not legible and no treatment plans were formulated.
- The service did not meet the ~~expectations~~ requirements of the Mental Capacity Act 2005. ~~and despite~~This was ~~identify~~identified~~ing~~ ~~this within the own~~ in the organisations audit and no action had been taken to support staff until they had received training.

However

- The service demonstrated improvement in staff supervision and appraisal.
- Staff attended team meetings.
- Mental Health Act documentation was in good order.

Are services caring? **Requires Improvement**

We rated caring as requires improvement because:

- Care plans were not person-centred ~~because~~ as ~~sufficient attention to~~ patients communication needs had not been addressed.
- There was limited information to show how staff supported patients with limited communication to make decisions about their care and treatment.

However

- Patients told us staff treated them with dignity and respect.
- Patients attended weekly community meetings where they could express their views of the service.
- Patients had access to advocacy services.
- The service set up a family forum to involve family carers.

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

We rated responsive as requires improvement because:

- The hospital had an intensive support suite which had no established criteria for admitting patients. ~~admitted t~~Two patients ~~to an intensive support suite, which had no established~~had been admitted there.
- Ppatients did not have a discharge ~~plan despite~~plan. Some patients ~~being~~were in the process of moving to a different service.
- Tthe service did not have an evidenced based approach to ensure ~~analysing~~ therapeutic based activities~~, which made sure they~~ reflected patient needs.
- Staff did not complete environmental assessments regarding patient sensory deficits and mobility.

However

- Patients had access to lounge areas and leisure activities to support independence.
- Patients had access to phones and computers.
- Religious and spiritual needs were identified.
- Patients told us they knew how to complain and the service received only 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 did not know the organisation's visions and values.
- -The service did not provide adequate mandatory training on the Mental Capacity Act or the Mental Health Act, to ensure patient's rights would be upheld.
- ~~The service did not provide adequate mandatory training so patients were at risk because their rights were not protected~~
- Staff sickness rates were high at 12%.

- The service did not take action on key areas identified within its own governance systems.
- ~~Although s~~Staff spoke positively about their manager but~~, they~~ described the overall staff morale as “ok” and acknowledged it fluctuated.

However

- Staff supervision was improving.~~,~~
- Staff demonstrated a clear desire to improve their practice and make sure patients received high quality care.

Detailed findings from this inspection

Do not include in report

Mental Health Act responsibilities

Only 5% of ~~S~~staff had ~~limited~~ recieved training in the Mental Health Act (MHA) and ~~the~~ its Code of Practice~~. with only 5% of staff having received training~~.

A MHA monitoring visit took place in January 2015 where it was established patients were detained correctly and had access to tribunals and managers meetings. 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 information regarding patients’ rights. We brought this to the manager’s attention and this was rectified immediately.

Patients were able to have leave under section 17 of the MHA, and this was not cancelled due to staff shortages.

Commented [[redacted]9]: I’m not sure why we are detailing this?

Commented [[redacted]10]: Was this from the inspection or the Jan MHAR visit?

Commented [[redacted]11]: Was there anything to collaborate this?

Do not include in report

Mental Capacity Act and Deprivation of Liberty Safeguards

An internal audit in June 2015 identified that the service was not meeting the ~~expectations or~~ requirements of the Mental Capacity Act 2005 (MCA). 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 which commented on a patients ability to make decisions regarding their care and treatment. 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. Only 10% of staff had received any training in relation to the Mental Capacity Act 2005.

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

Commented [[redacted]12]: Is this documented approach or was there no approach?

Commented [[redacted]13]: Applications or authorisations?

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 safe?

Requires Improvement

Safe and clean environment

~~-~~The service needed to make improvements to the safety of the outside areas because they posed ~~many~~ risks to staff, patients and visitors. For example, there was a large skip in the hospital car park~~,~~ which contained debris and long planks of wood with large nails attached. Patients had access to the skip and staff had not made a risk assessment of it. Five of the seven patients had a history of assaulting others~~,~~ which also included using objects as weapons~~...~~.

The garden area contained a large amount of broken glass, wood, nails and large rocks. ~~Again, t~~This was a~~n potential~~ area where patients could ~~get hold of~~obtain materials they could use to harm themselves and others.

There were no clear lines of sight within the hospital, ~~which meant~~ staff could only observe~~d~~ patients when in each patient area. Staff did not carry out observations in accordance with individual risk assessments and the organisations current 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. We saw staff left these two patients alone and unsupervised. One of these patients required eyesight observations because of their ~~known~~ history ~~to~~ of assault~~ing~~ people.~~.~~

We carried out an unannounced night inspection on 5 August 2015 to observe patients care at night ~~but to also~~and 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 eaten an evening meal. No members of staff were in patient areas even though some patients required one to one support and eyesight observation. We raised our immediate concerns with the nurse in charge that staff did not follow patients' care plans. We were told by one member of staff that staff routinely ate together in the evening and then concentrated on

cleaning duties. Three other staff told us staff did not always occupy patient areas and that if patients left their rooms it activated the door alarms. They said they used the alarms to support staff in their observations.

During our inspection on the evening of the 5th August 2015 ~~-~~bedroom door alarms were activated and we timed how long it took staff to deactivate them. It took staff almost two minutes on one occasion. ~~Because the s~~Staff could not see who or how many patients had left their room~~, or how many patients had left their rooms, it~~ this put patients at risk~~. if one of those patients posed a risk to others.~~ Staff ~~did not and~~ could not observe patients as required ~~on their records~~by their care plans. The door alarms did not mitigate the known risks to patients who needed eyesight observation~~. as noted on their records.~~

Patient rooms did not have observation panels on the doors~~,~~ so staff could not maintain eyesight observation when a patient was in their room with the door closed. No protocol was available to advise staff on how deal with this.

Commented [[redacted]14]: Could staff describe how they dealt with this?

We requested to review the observation records for patients' on the evening of 5 August 2015 but there were no records available. Staff told us they completed the records in patient notes at the end of their shift. This ~~was against~~did not meet the organisation's policy requirements and put patients' and others at risk of harm ~~because.~~ ~~s~~Staff failed to observe patients' in accordance with ~~their~~ identified risks and care plans.

A ligature risk assessment~~,~~ completed in July 2015~~,~~ identified a number of concerns such as door handles and window openers. The response to each concern was that staff would manage risks locally. There were no details in the assessment or patient records to show how staff managed the risks.

The service was clean and they took steps to minimise the risk of infection. The service employed domestic staff~~,~~ responsible for daily cleaning. There were cleaning schedules and audits to reduce the possible risk of infection. One bathroom in an unoccupied area was dirty~~,~~ and it was unclear when this was used last.

Safe staffing

The service did not have enough staff. Staffing was assessed in accordance with NHS England Staff Guidance and the service did not use any other types of dependency assessment tools. Night shift staffing levels failed to meet the needs of patients~~'~~ effectively. For example, staffing was set at five members of staff, which included one nurse and four support workers. However, one patient needed five members of staff to de-escalate an incident if 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 indicated it took a considerable number of hours to make successful contact with the on-call person in charge~~,~~ and staff had to call the police.

The service had not considered staffing levels at night appropriately. Incidents ~~clearly~~ happened in the evenings and required all staff to deal with them. This meant there were no staff to manage the needs of other patients

We saw two patients who required eyesight observations were left unattended because night staff were cleaning.

We asked the service to provide us data regarding the establishment staffing levels prior to our inspection. The information provided was:

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. The manager reported the service had difficulty recruiting staff because of its location and poor transport links. The service implemented a staff recruitment strategy to look at new ways of attracting employees.

Staffing levels during the day were usually one qualified nurse and eight support staff, or sometimes two qualified nurses and seven support staff. Staffing rotas confirmed each shift had the required number of staff. The hospital manager could request additional staff when patient needs dictated.

The service did have records relating to mandatory training. We looked at the records they gave us and noted that there were significant gaps in some areas. For example:

- 10% of staff completed training in Mental Capacity Act and Dd~~d~~eprivation of liberty safeguards.
- 5% of staff received training in mental health.
- 36% of staff received infection control.
- 77% of staff received training in equality and diversity.

This training was provided by e-learning through the Danshell Academy.

Where training was delivered as a group the attendance rate it was significantly higher. For example ~~areas such as~~:

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

Assessing and managing risk to patients and staff

Staff told us that the service did not have a seclusion room because the service did not do this. Staff showed us a designated room referred to as "room 10"~~, a~~, a low stimulus room. Four members of staff told us they took patients to the room ~~who~~ and held them in restraint if they were distressed. The Mental Health Act 1983 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:

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 staff used the room. There was no policy or guidance for the use of the room and equally no appropriate safeguards to ensure the room was used as intended. None of the patient care records had care plans for the use of seclusion.

In the previous six months, there had been 129 incidents of restraint involving 10 patients. None these were in the prone position. Prone position restraint is where a person is held face down and can cause serious harm and even death.

We looked at the risk assessments of all seven patients. The risk assessment tool used by the service was a "risk screening and assessment tool". The Danshell group developed the tool, but it had not been validated externally. Nursing staff we spoke with had a poor understanding of its use and did not use in accordance with the organisation's methodology.

~~The risk assessment tool did not use a formulated evidence based approach. So s~~Staff rated risks using a number system~~,~~ which was subjective and based on nurses opinions. There were gaps in the risk recording and information was inconsistent. One patient's records identified they presented no risks of inappropriate sexual behaviour but details in the care records stated that a ~~e~~ patient had attempted to intimately touch others ~~,~~ on a number of occasions.

Nurses completed the risk ratings and assessments. These were not agreed by the multidisciplinary team. ~~-~~ 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 organisations should consider using a formal rating scale such as Aberrant Behaviour Checklist or Adaptive Behaviour Scale. ~~This would provide baseline levels for patient's 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 staff reviewed risk assessments on a six monthly basis~~,~~ or where a patients increased needs occurred. We expressed our concerns about the absence of regular reviews of risk management plans.

Staff demonstrated little understanding of autism, communication needs or recognised best practice. This contributed to a limited understanding of individual needs. As a result, there were high levels of restraint and restrictive practice to manage difficult and complex behaviour.

The service managed medicines correctly. The clinic was tidy and worktops were clear of any objects or paperwork. 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~~in line with the medicines management policy, ~~with~~ copies of the prescriptions stored away in a folder.

We inspected all medication charts and found they were legally compliant, legible and in accordance with the Human Medicines Regulation Aact 2012. No missed signatures were noted by nurses administration in the drug cards.

Commented [[redacted]15]: This is the old code definition. I'm not convinced we are describing seclusion here. Did the staff release restraint and prevent the person from leaving? Did they deescalate the situation , release restraint and help the person to reintegrate?

Commented [[redacted]16]: This would help us decide if the practice is seclusion or not.

Commented [[redacted]17]: Was there a restraint policy? This may help with the above

Commented [[redacted]18]: Are we sure there was no external validation?

Commented [[redacted]19]: Were they discussed at review meetings?

Commented [[redacted]20]: So they should have been reviewed but hadn't?

Commented [[redacted]21]: We need to quantify this or take it out

Care plans were written in detail where patients required medication on an “as and when required basis” However, not all patients had a review of medication used for rapid tranquilisation. The service did not follow the National Institute of Health and Care Excellence guidelines (NG10) Violence and Aggression point 1.3.11.

Evidence was present in the multidisciplinary team notes that the patient’s doctor reviewed “as and when required” medication but it was not in line with the above recommendation. Also some patients did not use “as and when required” medication for rapid tranquilisation but was still present on drug cards. In general where patients’ did not use “as and when required medication, whether psychotropic or for physical health, doctors did not review or stop it, where appropriate.

The organisation did not have a policy relating to rapid tranquilisation. This meant nursesMedicines were administered drugs without any organisational guidance on the its appropriate use.

Nurses completed medicines management audits annually, with the most recent on 30 June 2015. The last three we reviewed were: medicines management, “as and when required” medication and controlled drugs. Nursing staff did not engage with any Prescribing Observatory for Mental Health UK audit.

Commented [[redacted]22]: So good or bad?

The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health tTrusts/healthcare organisations improve their prescribing practice. POMH-UK, with its member organisations, identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes (QIPs).

The medicines management policy was out of review date as it was due due for review in July 2015, and therefore out of date. The policy stated that two nurses had to sign for the administration of controlled drugs but the service often operated only one nurse per shift.

Commented [[redacted]23]: Did they use CD’s then, how did they mange this? Was there a Controlled Drugs Accountable Officer as detailed in The Controlled Drugs (Supervision of Management and Use) Regulations 2013 Information about the Regulations from DH I think this is a MUST

Staff told us that a pharmacist only visited the service once a year and did not participate in multidisciplinary 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 did not receive training in the administering of life saving medications so called the emergency services if necessary. However, emergency lifesaving equipment was available and tested daily to make sure it was ready to use in an emergency.

Commented [[redacted]24]: More specific please

Commented [[redacted]25]: Were staff trained in life support use of automated defibrillators etc. (as they use restraint they should be)

The service had arrangements for protecting patients’ from abuse. Staff knew how to raise concerns and report incidents. Patients’ had accused staff of bullying and using inappropriate behaviour. Where patients’ had a known history of making allegations there were care plans with clear protocols for staff to follow. We did note in one patient’s records it stated, where they made allegations against staff the first step was to “ignore” the allegation and escalate only if they repeated it. However, we found no information detailing why the patient may make allegations against staff or how staff could support and protect them.

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. Patients’ did not know how they could protect themselves from abuse.

Commented [[redacted]26]: Do we mean assaulted?

Track record on safety

From October 2014 until April 2015 the service had four serious untoward incidents.

- Ttwo involved patient on patient assault.
- Ooone involved allegations against staff.
- Ooone related to a patient in distress.

Reporting incidents and learning from when things go wrong

Staff reported incidents 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 told us incidents were rarely shared between the team, other than at staff handovers or where the manager informed them. Staff told us there was no formal process for reflective practice.

We viewed medication errors within the service on the internal reporting system RIVO. There were three medication errors reported from August 2014 to August 2015. We discussed with a senior nurse the learning from errors and they told us the clinical governance department was in touch with services to share information. Nursing staff did not use any reflective tools after errors to improve practice or learn from the error.

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 made five allegations about staff conduct and behaviour. One further allegation had been made by an external organisation regarding staff conduct and behaviour. The service held internal investigations into the allegations but none of them were substantiated. There was no evidence that learning from these incidents took place.

The service had a policy on duty of candour and staff could tell us about their responsibilities under the policy. A senior manager could show us an example of when they had ~~to execute their duties because~~apologised following an incident. ~~occurred requiring an apology.~~ The service demonstrated their openness and transparency to learn from their mistakes.

Are wards for people with learning disability effective? **Requires Improvement**

Assessment of needs and planning of care

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

Patients ~~did have~~had health action plans and physical health care checks. ~~Although we did find w~~Where patients' were prescribed routine antipsychotic medication relevant physical health checks had not always been carried out. ~~For example, o~~One patients last electrocardiography (ECG) was done on 4 November 2013. In accordance with Mawdsley prescribing guidelines

Commented [[redacted]27]: Do we know what thus acronym is

Commented [[redacted]28]: Isn't this sharing then?

Commented [[redacted]29]: Do they need to use a 'tool' , was there reflection?

Commented [[redacted]30]: How did they do this

2014 this should be completed annually. We also noted that one patient's ~~the~~ last blood tests ~~for one patient~~ were done 18 June 2014 and ~~again~~ this should be done annually.

~~Evidence of~~Records of weight monitoring and blood pressure were present and were regularly being done. It is encouraged that side effects of medication 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.

Commented [31]: By whom?

The service used a care model called personal PATHS. The principles of the model were:

- p~~P~~ositive Behaviour Support
- a~~A~~ppreciative Inquiry
- t~~T~~herapeutic Outcomes
- ~~H~~healthy Lifestyles
- s~~S~~afe services

There was little understanding of this model or how it was embedded in the service. Senior managers could not describe the components of the model during their presentation of the service. ~~The service was given the opportunity to do a presentation too us on the first day of the inspection. We asked during the presentation for senior managers to describe the components of the model too us. Senior managers were not able to articulate what treatment was being provided in the hospital and also what was meant by the appreciative inquiry. There was an apparent lack of understanding of the organisations model and how it was embedded in the service despite this model being developed by the Danshell Group.~~

~~All~~ All the seven care plans ~~lacked~~ we looked at did not have a treatment plan. All staff ~~spoke of~~described positive behaviour support and activities~~,~~ but were unable to clarify what treatment was being provided other than medication.

Other areas we identified were:

- None of the p~~P~~ositive behaviour support plans ~~of each patient did not~~ contained ~~information that is pertinent to the principles of positive behaviour support. D~~details of communication styles, sensory needs ~~and~~, specific behaviours ~~and~~ or triggers. ~~were not incorporated within individual plans.~~ Plans were written in a format~~,~~ which was reactive to patient behaviour as ~~opposed to~~rather than preventative.

- There was limited assessment~~s~~ 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 mats". The patient had no talking mats available to use and staff had received no training in their use. Two staff who were supporting the patient ~~failed to~~did not understand ~~and grasp~~ the importance of the use of communication methods. ~~The two~~ Two members of staff ~~members~~ told us they did not use the patients preferred methods because "they wanted them to speak". A patient who had autism had no communication plan in place despite limited vocabulary. Makaton signs were not used

for a patient who understood these. Staff stated "If we use Makaton all the time they won't get any better".

- ~~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 the patient but this was poorly structured and did not use the individual's identified communication tools.~~

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

- Patients did not have 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. ~~The strategies that had been developed~~These were not incorporated into any care plan and there was no ongoing support to maintain positive behaviours ~~, such as reflective work~~. Staff could not evidence how the cognitive behaviour therapy was being used to support the patient in their care and treatment.

- Where patients had history of offending behaviour there were no psychological treatments being provided to reduce the risk of further incidents occurring.

- Staff had not received training in supporting people with mental health problems, despite some patients' having a diagnosed mental illness. Care records of patients with mental health difficulties did not have any treatment plans, strategies or interventions on how to support, care and treat the patient.

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

Staff told us they could make referrals to the in-house speech and language therapist but response time was slow, and there was no active involvement due to the services location.

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 during our inspection. Two staff members we spoke with who were supporting the patient did not know they had to carry out a risk assessment before every activity outside the hospital. Staff did not follow the care plan, which was in place to ensure patients received safe and appropriate care.

Best practice in treatment and care

The service did always follow best practice and guidance in regards to the care and treatment for patients with a learning disability and/or autism.

Commented [[redacted]32]: I'm sure I have read this already?

Commented [[redacted]33]: I'm sure I have read that some staff had training?

Commented [[redacted]34]: Was it that the staff hadn't formulated a care plan, didn't know how to provide care or was not following the care planned – the training isn't really the issue but did they have the skills and knowledge?

Commented [[redacted]35]: So was there any SALT involvement or was it that it was not used?

Commented [[redacted]36]: How often? sometimes

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 people who have complex behaviours. The service did not fully incorporate ~~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 service had not carried out any audits in relation to it meeting the expectations of~~ tThe National Institute of Health and Care Excellence: Autism Diagnosis and Management Guidance June 2012 ~~which clearly~~ sets out the requirement of strategy, analysis and functional assessments. The service had not carried out any audits in relation to this.

~~Although m~~Medication was ~~generally well~~ prescribed with no patients being prescribed medication over the BNF gGuidance. ~~t~~The service ~~did~~ required ~~some~~ improvements to ensure that 'as and when required' medication was reviewed accordingly. The service did not take into account National Institute of Health and Care Excellence: Violence and aggression short- term management in mental health, health and community settings May 2015 (1.2.16) and (1.3.11) and National Institute of Health and Care Excellence: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities who behaviour challenges. May 2015

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

The service ~~also~~ ensured each patient had a health action plan and patients received care to ensure their physical needs were met. However, ~~despite finding some areas for improvement such as~~ further health monitoring was required where patients were prescribed medication that could affect their physical health.

Skilled staff to deliver care

The service had a dedicated psychiatrist, occupational therapist and assistant psychologist dedicated to the service. ~~,~~ ~~H~~however the input from the disciplines was ~~minimal as~~ only 1.5 days of the week. ~~were spent at the service and much~~The majority of their time was occupied by multidisciplinary team meetings and ~~. Therefore,~~ there was limited time ~~dedicated to~~for patient assessment and supporting the nursing staff team. A report sent to us by the provider dated January 2015 titled "Internal service review" detailed that there had been no financial budget allocated for a speech and language therapist and clinical psychologist. The report detailed this was essential to the care and treatment of patients. ~~Despite the report being eight months old t~~The service had not ensured there was the correct support for both patients and staff.

Staff were not skilled to deliver effective care to patients. The service had a focus on positive behaviour support but 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. A further two staff had completed some training in Makaton, which is a form of sign language. Despite this the service did not use any effective communication models. Communication models support patients to develop and enhance their vocabulary. This ensures their needs are understood and met as well as ensuring treatment is

Commented [[redacted]37]: All care?? Or just PBS

Commented [[redacted]38]: So are we saying the training was tokenistic, insufficient, staff had not listened or taken it on board?

safe and effective. Staff demonstrated limited understanding of the importance of effective communication in both treatment and care,

Staff had not received any specialist training in autism despite some patients having a diagnosis. It was unclear what care and treatment patients with autism received.

All clinical staff confirmed they had at least six clinical supervisions a year and an annual appraisal. One member of staff told us they had received no supervision for ~~over a year and a half~~18 months. Senior managers recognised that 76% of staff had received an appraisal and this still required some improvement to achieve the organisations target?90% rate.

We did see one example where a staff member's contract was terminated after their probationary period because they were found to be unsuitable for the service. Senior managers explained they would take action to address poor performing staff.

Staff did attend team meetings and we were able to see the minutes of meetings from January 2015 to July 2015. The meetings showed that staff were able to contribute to the meetings and areas such as employee allowances were discussed as well as commitments to improve training and supervision.

Multidisciplinary and inter-agency team work

Patients were invited to weekly multidisciplinary team meetings. ~~We saw instances where p~~Patients had raised issues such as length of time it took for discharge and clarification regarding what alternative placements were being sought. ~~It was clear from the R~~records suggested patients were not progressing from the service until suitable placements were identified by their care co-ordinators.

Multidisciplinary teams consisted of doctor, nurse, support workers and other allied health professionals such as occupational therapist and psychologist. The service did invite external agencies to the multidisciplinary meetings, such as commissioners. They often did not attend and subsequently did not contribute to the meetings but were sent the minutes.

The quality of the written multidisciplinary 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 treatment plan. There was ~~equally~~ no evidence of how the clinical audits carried out influenced overall clinical practice. Minutes of meetings we reviewed did not demonstrate how the audit process improved practice.

We observed one handover. The information provided to staff during the handover describing the patients day including activities rather than 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

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

Commented [[redacted]39]: I think we have already said this

Commented [[redacted]40]: So are we also saying they didn't know anything about it?

Commented [[redacted]41]: Is this good bad or indifferent?

Commented [[redacted]42]: How could they if they were not invited?

A MHA monitoring visit took place in January 2015 where it was established patients were detained correctly and had access to tribunals and managers meetings. 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 information regarding patients' rights. We brought this to the manager's attention and this was rectified immediately.

Patients were able to have leave under section 17 of the MHA, and this was not cancelled due to staff shortages.

Commented [43]: See amendments and comments above

Good practice in applying the MCA

An internal audit in June 2015 identified that the service was not meeting the expectations or requirements of the Mental Capacity Act 2005 (MCA). 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 which commented on a patients ability to make decisions regarding their care and treatment. 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 who were subject to Deprivation of lLiberty sSafeguards, ~~(DoLS).~~ applications.

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 them. A senior manager acknowledged what happened was both embarrassing and inexcusable.~~
During the provider presentation on the 4 August 2015 one of the patients took part in the presentation but had difficulty with reading the script and communication. This led to an uncomfortable situation that the staff were unable to manage effectively.

We spoke with four patients during our inspection and our expert by experience participated in one activity with patients. ~~to understand their experience further.~~ We observed patients were treated in 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 in a compassionate and caring manner offering reassurance to minimise further distress.

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. Patients 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 and people were effectively included in the decisions, which effected them.

Commented [[redacted]44]: I think I have read this somewhere

The service had ~~attempted to complete some~~ person-centred plans but ~~however,~~ these were incomplete for almost all patients' and ~~had little~~didn't focus on increasing skill and independence. Plans had not been developed in line with how patients communicated. There were ~~other than~~ some easy read templates but these were~~, which was~~ not suitable for all patients. The service told us 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~~'~~.

The service held 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 maintenance work however, the issues remained outstanding. , ~~as action had not been taken.~~

The service had set up "family forums" where issues such as organisation polices were discussed to ensure those families representing patients were included in the way the service functioned. ~~We saw from T~~the minutes of ~~meetings~~ forums showed that work had been done to develop a brochure for Whorlton Hall detailing the admission and discharge process and ~~equally~~ what to expect from the service. The Brochure had been produced in easy read for patients to support them in their understanding of the service.

The service had sent out and received responses back to the satisfaction questionnaires it had produced. ~~However t~~The results were not available to us at the time of the inspection~~,~~ but minutes of clinical meetings held in June 2015 suggested that the survey response was positive.

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

Access and discharge

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

Pre-admission and admission assessments, risk assessments and positive behaviour support plans were not individualised~~standardised~~. ~~Elements~~ Parts of these were repeated across patients care records as though text had been copied and pasted.

Commented [[redacted]45]: Had they been copied and pasted or not?

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.

Commented [[redacted]46]: What best practice?

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 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 one patient had been discharged that had been accommodated ~~as long as~~for 14 years. Patients did not have a discharge plan in place, ~~and~~ senior managers recognised this as an area for development. The hospital reported that there had been one delayed discharge between 1 February 2015 and 1 August 2015 because the person was awaiting an identified placement.

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.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital was spacious with a variety of areas where patients could be engaged in activities. Patients ~~appeared to regularly~~ used a lounge area with ~~facilities~~ hospital? to watch TV and play pool. The service had ~~also developed~~ a computer suite~~, however~~ but this was not ~~up and running~~operational during our inspection ~~and was still within its infancy~~. Patients did tell us they had 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. No environmental assessments were in place to ~~demonstrate~~ identify the patient's needs ~~had been taken into account~~.

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

Patients told us that the quality of food was reasonably good in the service. Minutes from management meetings stated that food quality had improved and patients enjoyed a range of healthy dishes with a variety of choice each day. We observed patients being offered a range of food choices during meal times. These were presented in picture format so patients who had limited verbal communication were able to express their choices effectively to staff.

Patients had access to outside space and were able to sit in garden areas ~~should they wished~~when they wanted to. Doors were not locked so patients were able to move around freely with support from staff ~~had the need been identified~~when required.

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.

Commented [[redacted]47]: This is detailed above

Commented [[redacted]48]: Is this 25 months?

Commented [[redacted]49]: None of them?

Commented [[redacted]50]: Was this within the hospitals control and/or what had they done about it. If nothing then we need to say.

Commented [[redacted]51]: Not sure what this means?

Commented [[redacted]52]: Internet or just word etc? I think this was highlighted as good practice above so needs to be clear.

Commented [[redacted]53]: Did they have a policy for use and how did they identify risks of their use?

Commented [[redacted]54]: This is an example of meeting the needs of the patients communication difficulty which has been criticised above

However despite these approaches being adopted tThe service had nocould not provide evidence to demonstrate how these assessments were incorporated into patients daily lives and activities. There was no review mechanisms in place.

We spoke withThe two members of staff who hadwith responsibility for activity co-ordinating. Neither had not received training in a human occupationalMOHO model. andThey were not aware of what it was or how such a model was implemented.

We looked at tThe activity records for each patient and foundshowed that they engaged in a range of activities such as going to the shops, going for walks, horse riding, cooking and other leisure activities. However, Ttthere was no format for establishing the therapeutic outcome or gain for the activities patients engaged in.

Staff told us patients could chose not to engage in activities and we saw evidence of this occurring., Hhowever there were no interventions or strategies within care plans to train and support patients in identified areas of need which wouldto enhance their quality of life and support their recovery.

We observed a cooking session delivered by the hospital chef. We found tThere was no structure to the session, instructions to patients participating were unclear and there was no clear direction been given. The staff member concernedhospital chef had not received any training in delivering sessions to patients with complex needs and lacked did not have the overall skills required. However, we did note the staff memberthey did treated patients with kindness and did makemade a significant effort to support patients.

Staff told us that some patients engaged in a programme called award scheme development and accreditation network (ASDAN) "ASDAN" which is a curriculum aimed at skills for life. However, there wascare records made no reference to how patients were being supported with the programme within their care records, and or how the programme was being adopted to reflect the learning styles. of patients within the hospital given that is the curriculum is not designed for those with a learning disability and/or autism who reside in hospital. The programme is aimed at people who are within school or college settings.

We saw information relating to advocacy services on patient information boards and saw evidence of advocacy referrals in care records. Patients we spoke with told us they knew who the advocate was and they were able to speak with the person should they want too.

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

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 with the exception of senior managers did not know what the organisations vision and values were.~~ The service had ~~created~~ adapted their own version of vision and values and this was displayed on a wall, but this was not a clear ~~interpretation~~ reflection of the organisations vision and values. Only senior managers knew what the organisations vision and values were.

Staff knew who senior managers were in the organisation and told us they frequently visited the service.

Good governance

The organisation had a quality strategy with a16 point improvement intervention plan to be completed at a local level. Team meeting minutes 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 meetings 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.

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

The hospital was subject 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 audit.

- All three audits ~~fell short of~~ did not meet the organisations ~~pass rate~~expected compliance level and actions had been set.

- We saw a recent infection control audit which had achieved the required compliance level ~~pass rate~~.

- The service prepared monthly internal service reviews which were discussed with the senior governance team and 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 which was an environmental ligature risk assessment from February 2015.The assessment was completed in July 2015.

Commented [[redacted]55]: So it was complete but late?

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

The unit had a risk register with ~~clear~~ actions in place to reduce risks occurring. The risk register ~~did~~ highlighted serious concerns regarding care planning and risk assessment as well as increased levels of restrictive practice. There were action points in place to support the service to reduce the levels of risk~~,~~, H~~h~~owever, at the time of the inspection these still remained unachieved.

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 M~~m~~ental C~~c~~apacity A~~a~~ct and ~~m~~Mental H~~h~~ealth A~~a~~ct.

Leadership, morale and staff engagement

Staff ~~reported~~ said the hospital manager was accessible and provided good support.

Staff described morale as "OK" "fluctuates" and "getting better". They said they felt able to speak up and ~~would~~ go to higher senior management if ~~the need ever arose~~this was required. They ~~were able to tell~~told us about the organisation's whistleblowing policy and ~~how they would not hesitate to blow the whistle on poor practice should they find it necessary.~~that they felt comfortable about using it.

Minutes were available from bi-monthly staff team meetings, these ~~which~~ showed a wide range of ~~items~~ topics were discussed. We saw areas for improvement from service reviews 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 worked well together. We saw assessments of risk~~,~~ which required staff to work in pairs with some service users. ~~but they~~Staff did not always follow this. Staff carried personal alarms and we ~~witnessed~~ saw responses to alarms during our visit.

- The average sickness rate was 12%
- Supervision and appraisals compliance was 76%

Sickness, supervision and ~~Both of these areas along with~~ staff recruitment ~~remained~~ were concerns for the service. ~~However there was~~The service had an action plan to address the ~~shortfalls identified~~these areas ~~and~~ which was monitored on a monthly basis through regional management meetings.

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.

Commitment to quality improvement and innovation

The service demonstrated a willingness to learn throughout the inspection and were eager to improve. ~~on the shortcomings identified~~.

The service was not participating in any research projects during the time of our inspection.

Commented [[redacted]56]: How many?

Commented [[redacted]57]: How many

Areas for improvement

Areas for improvement

Do not include in report

Action the provider MUST take to improve

- The service MUST ensure the physical environment internal and external does not present a risk to patients, staff and visitors.
- The service MUST ensure patients are appropriately supervised and observed at all times in accordance with their assessed needs and risks.
- The service MUST ensure there are adequate staffing levels and staff are appropriately deployed to carry out their duties.
- The service MUST ensure staff are competent and skilled and have received adequate training and supervision to ensure the needs of patients are met.
- The service MUST ensure care plans reflect the care and treatment needs of patients and they are holistic, person-centred and recovery focused.

- The service MUST ensure policies and procedures relating to the running of the service are up to date.
- The service MUST ensure written documentation with patient notes reflects comprehensively the care and treatment required.
- The service MUST ensure patients have a robust discharge plan in place
- Controlled drugs management?

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	Regulation 9 HSCA 2008 (Regulated activities) Regulations 2014 Person-centred care Patients did not have care plans that were person-centred, holistic or presented in a way their met their communication styles. This is a breach of regulation 9 (1)(a), (b), (c) (2) (a),(b) (c) (d) (e) (4) (5) (6)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated activities) Regulations 2014 Consent to care and treatment. Patient did not have adequate capacity assessments carried out because staff had not used effective communication aids to support patients throughout the assessment process. This is a breach of regulation 11 (1) (a)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated activities) Regulations 2014 Safe Care and Treatment Patients did not receive care in accordance with their assessed needs. The service did not follow best practice and guidance in relation to supporting patients with communication difficulties and complex behaviours. Equally staff had not received specialist training to support them in their role to care for patients with the level of complex needs they presented. Patients were taken to a room and held in restraint where they posed a risk to themselves and others, however there were no care plans or protocols in place to protect patients. Patients also did not have any discharge plans in place. This is a breach of regulation 12 (1) (2) (c),(i) (c) (d) (e)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated activities) Regulations 2014 Premises and equipment.

	The environment posed risks to staff, patients and visitors and audits and assessments had not been carried out. This is a breach of regulation 15 (1) (b) (c) (d) (e)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated activities) Regulations 2014 Person-centred care Patients records were not always up-to date. For example recording of multidisciplinary team meeting were missing from records. Information in care records was not always updated where changes occurred.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated activities) Regulations 2014 Staffing. Staff did not ensure there was sufficient staff on duty with the necessary skills, training, supervision and appraisal to ensure patients' needs were adequately met. Night staff were also not appropriately deployed in their duties to meet patients' needs. This is a breach of regulation 18 (1) (2) (a)