

# Whorlton Hall

## Quality Report

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

### Ratings

#### Overall rating for this location

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

### We rated Whorlton Hall as good because:

- Patients received care in a clean and safe environment. When we visited in August 2015 the external environment had not been adequately assessed and a number of hazards in the grounds were placing patients, staff and visitors at risk of harm. These hazards were no longer present when we visited in March 2016.
- There were enough staff on shifts of different disciplines and the service was recruiting to fill the vacant posts for qualified nurses and support workers. When we visited in August 2015 it was unclear if staffing levels met the needs of the patients. A review of staffing levels had since been undertaken.
- Staff were kind and respectful to patients and recognised their individual needs.
- Staff had been trained and knew how to make safeguarding alerts.
- Staff had received training in the Mental Health Act and the Mental Capacity Act. When we visited in August 2015 few staff had received this training.

- Staff morale was good and the team worked well together.
- Governance processes identified where the service needed to improve. This had led to improvement plans being put into place for the service.

However:

- Emergency equipment was out of date and the service lacked the medicines required in an emergency which their policy described as “essential stock”.
- There were some discrepancies between medicine labels and the prescription chart. The provider’s medicine policy did not advise staff how to manage these discrepancies. Some medications with limited life after opening did not have the date of opening recorded. There was an excess of stock of one medication.
- Carers did not always feel involved in their relatives’ care.

# Summary of findings

## Contents

### Summary of this inspection

	Page
Background to Whorlton Hall	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the service say	6
The five questions we ask about services and what we found	7

### Detailed findings from this inspection

Mental Health Act responsibilities	9
Mental Capacity Act and Deprivation of Liberty Safeguards	9
Outstanding practice	19
Areas for improvement	19
Action we have told the provider to take	20

Good 

# Whorlton Hall

## Services we looked at

Wards for people with learning disabilities or autism.

# Summary of this inspection

## Background to Whorlton Hall

Whorlton Hall is an independent hospital owned by the Danshell Group. It provides assessment and treatment for men and women aged 18 years and over living with a learning disability and complex needs. The hospital also cared for people who had additional mental or physical health needs and behaviours that challenged.

It is registered with the Care Quality Commission to provide the following regulated activity:

- Assessment or medical treatment for people detained under the Mental Health Act 1983/2007.
- Treatment of disease, disorder or injury.

The hospital's registered manager had been in post since 2015.

The hospital had been registered since 2013 to accommodate 24 patients. However changes to the layout and environment meant this had been reduced to 19 beds. At the time of our visit there were seven patients at the hospital.

The hospital was visited in August 2015 as part of the comprehensive inspection programme. There was concern about the August 2015 inspection and not enough evidence was gathered. It was therefore agreed to repeat the inspection. This report covers both the main findings of the August 2015 inspection and the inspection undertaken in March 2016. The rating is based on what we found in March 2016.

## Our inspection team

The team that inspected the service comprised of two CQC inspectors and one learning disability nurse specialist advisor.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with four carers
- spoke with the registered manager
- spoke with 13 other staff members including doctors, nurses, support workers, activity co-ordinator, occupational therapist, business support administrator, student nurse and psychologist
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management

# Summary of this inspection

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

## What people who use the service say

At both of our visits in August 2015 and March 2016 patients told us they felt safe and liked staff. They had a range of activities arranged for them and had copies of their care plans. Some patients told us they had an advocate and that staff told them what their rights were every month.

Some patients said they wanted to see more of their family and move closer to home. One patient told us they would like a small kitchen so the male patients could make their own drinks like the female patients could.

Three carers told us they thought the hospital was too far away and wished their relative was nearer. Some carers we talked to had never visited the hospital because it was too far away from where they lived.

# Summary of this inspection

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

We always ask the following five questions of services.

### Are services safe?

We rated safe as requires improvement because:

- Appropriate equipment and medicines required in an emergency were not available.
- There were discrepancies between medicine labels and the prescription chart and the provider's medicine policy did not advise staff how to manage these discrepancies.
- Some medications with limited life after opening did not have the date of opening recorded.
- There was an excess of stock of one medication.
- A recording form for observations was not always completed as per the provider's observation policy.

However:

- Environmental risk assessments had been completed and actions taken to ensure a safe environment.
- There were enough staff providing direct care to patients on each shift.
- Staff were up to date with mandatory training. They had been trained and knew how to make safeguarding alerts.
- Incidents that should be reported had been reported.

Requires improvement



### Are services effective?

We rated effective as good because:

- Staff did comprehensive assessments on admission.
- Care plans were up to date personalised, holistic and recovery focused.
- Patients had good access to physical healthcare.
- Staff received appropriate induction, regular supervision and annual appraisal.

However:

- The service did not have up to date policies in line with the revised MHA code of practice.
- Although learning disabilities specific training, including communication, had been introduced, not all staff had completed this.
- The recruitment of a dedicated speech and language therapist was ongoing.

Good



### Are services caring?

We rated caring as good because:

Good



# Summary of this inspection

- We observed staff being kind and respectful to patients.
- Patients told us they liked staff.
- Staff recognised patients individual needs.
- Patients had a copy of their care plans and staff involved them in their care planning.
- Patients had access to advocacy support.
- Patients were able to give feedback through regular 'house meetings'.

However:

- Carers did not always feel involved in their relatives care and due to the location of the hospital, they could not always attend multidisciplinary team (MDT) meetings.

## Are services responsive?

We rated responsive as good because:

- Records showed that patients' discharges were being planned for.
- There was enough space and rooms for patients to receive therapeutic activities.
- Activities were tailored to patients' preferences and interests.
- Information was available in an accessible format.
- Patients were able to raise complaints or issues.

Good



## Are services well-led?

We rated well led as good because:

- Staff knew who the senior leaders in the organisation were and told us they visited the service.
- Key performance indicator information was used to monitor quality and performance.
- There was a commitment towards continual improvement and innovation.
- The service was very responsive to feedback from patients.

Good





# Detailed findings from this inspection

## Mental Health Act responsibilities

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

Staff were trained in the Mental Health Act (MHA) as part of their mandatory training. The training included awareness of the updated MHA code of practice. Staff interviewed showed a good understanding of the legislation.

MHA documentation was completed appropriately. Risk assessments were completed consistently and updated regularly. Care plans were reviewed regularly and an appropriate range of meaningful activities were available to patients.

Section 17 leave forms were clearly written. Staff told us that section 17 forms were reviewed prior to patients' activities outside the hospital to ensure they had the correct authorisation to attend.

Patients were informed of their rights and we saw repeated attempts to explain rights using easy read material. All patients had current mental capacity assessments. Ministry of Justice authorisation was present where appropriate.

Consent to treatment certificates, T2s and T3s (which authorise the patients treatment) were held with the medication cards. We reviewed these and found them to be in order. We saw referrals to second opinion appointed doctors were made appropriately.

Patients were automatically referred to an independent mental health advocacy service and we saw evidence of independent mental health advocates attendance in the patients' records.

Monitoring of the application of the MHA and its code of practice was provided by a central team. Staff knew how to contact the team and used them regularly for advice and training. We saw an action plan in relation to the revised code of practice. The action plan consisted of policies and procedures which required updating following publication of the code in April 2015. Several of the policies had not yet been ratified which meant that staff did not have up to date guidance to support them in meeting the requirements of the new code of practice. Although we did not see any evidence that the principles and guidance of the code were not being implemented, we were concerned at the lack of progress with regards to updating policies.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) as part of their mandatory training. Staff were able to tell us about how they would assess patient's mental capacity and support patients to make decisions on a daily basis. Staff were aware of using different communication aids to support patients to make their own decisions.






More complex assessments of capacity were discussed in the MDT and we saw evidence of mental capacity assessments for finance and medication. MCA documentation and best interests decisions were routinely audited. The use of restraint was reviewed and audited.

Staff were aware of their responsibilities for arranging independent mental capacity advocates (IMCA) and we saw information displayed on notice boards.

One patient was subject to a DoLS authorisation at the time of our visit. We reviewed the record of this authorisation and found it to be in date and complete.

Advice and guidance for the MCA and DoLS was received from the central MHA department. All staff interviewed knew how to contact this team for support and advice.

# Wards for people with learning disabilities or autism

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

## Are wards for people with learning disabilities or autism safe?

Requires improvement 

### Safe and clean environment

The hospital was housed in a converted period house. The layout meant it was difficult to observe all patients as there were no clear lines of site. This however, was mitigated as all patients were on 1:1 or close observations. Staff told us that patients who could be out of site were risk assessed to ensure their safety. A ligature point audit had last been completed in February 2016. A ligature point was a place where a patient intent on self-harm might tie something to strangle themselves. When we visited in August 2015 a ligature audit then did not show how risks were being managed. The ligature audit of February 2016 was comprehensive and covered all areas including doors, bathrooms, and basins. A number of ligatures were identified and staff mitigated these through risk assessment and patient observation. The audit did not show a scoring matrix to identify the severity of the ligatures.

Patient bedrooms were located on the ground and first floor. Bedrooms had ensuite facilities and were split to provide separate sleeping areas for male and female patients complying with same sex accommodation requirements.

Male and female specific lounges and living areas were also available which meant patients had a choice if they did not want to use the communal lounges.

We were informed there were no emergency drugs on site. For medical emergencies, staff needed to call the emergency services. However, the provider's medicines policy indicated essential stock items, including medication for anaphylaxis, should be available on site which it was not.

A defibrillator and emergency equipment was available and regularly checked. However, when we looked at other equipment for use in an emergency we found that facemasks were not clean or sealed. Airways had passed their expiry date. A number of eye pads, dressings and bandages in the clinic room and first aid kit had also passed their expiry date. This meant that this equipment was not safe to use. We brought this to the staff's attention who took immediate action to have the items replaced. This was done within the period of the inspection.

The clinic room was clean, tidy and well arranged. Equipment necessary for examinations and monitoring of basic medical observations was available. Daily room temperature and fridge temperatures were recorded and observed to be within safe limits.

The hospital did not have a seclusion room. Following discussions with staff and review of care records we were satisfied that seclusion was not taking place in any other rooms.

The hospital was visibly clean with good furnishings and adequate decoration. We saw cleaning schedules and domestic staff were on duty. Cleaning records were up to date with the exception of one week which the ward manager explained was due to staff sickness. Although cleaning had taken place during this week, it had not been recorded.

# Wards for people with learning disabilities or autism

Staff followed infection control principles. Handwashing facilities and alcohol gel were provided.

Infection control audits were carried out.

An environmental risk assessment was last completed in February 2016 and included monitoring of the grounds and internal building. When we visited in August 2015 the outside areas contained some risks to patients, staff and visitors such as broken glass and nails. At our recent visit we saw that these risks were no longer present.

All staff carried personal alarms and nurse call systems were in bedrooms and bathrooms.

## Safe staffing

Staffing of the hospital was based on patients' needs and consisted of shifts from 8am – 8pm and 8pm – 8am. When we visited in August 2015 we were unclear if the staffing levels were meeting the needs of the patients, particularly at night. When we visited in March 2016 the minimum numbers of staff on a day shift was two qualified nurses and seven support workers. In addition to this, the registered manager and activity co-ordinators would be on duty. At night the minimum staffing level was one qualified nurse and five support workers which was able to be reduced to four support workers based on patient risk. The registered manager was able to adjust staffing levels if patient presentation or activities required this. Agency staff were used to fill gaps in staffing. The manager told us that wherever possible well known staff were used who had previously worked at the hospital. We saw evidence of this on staffing rotas.

We looked at the duty rota which showed that the numbers of staff required matched the number of staff on duty.

We were told that when staffing levels fell below these numbers, for example due to staff sickness, risk assessment and liaison with directors took place to ensure patients and staff were safe. We saw evidence of this happening.

At the time of our visit the provider had three support worker vacancies and two qualified nurse vacancies. Active recruitment was taking place and there had been a large response to recent support worker advertisements. Seven vacancies were currently under offer.

There were mixed views from staff regarding staffing with some staff feeling the hospital was often short staffed and

relied on agency staff who didn't know the patients. Some staff said the hospital had been short staffed recently, however, they did not feel it was unsafe as staff covered each other.

Some staff reported that activities were never or rarely cancelled due to staffing levels. However two staff members told us that activities were cancelled at times due to not enough staff. One person told us leave was sometimes cancelled because there was not enough male staff but generally planned activities went ahead.

All patients were on close or 1:1 observations and qualified nurses spent time in the communal areas and in 1:1 time with patients.

Medical cover was provided by a consultant psychiatrist who attended the hospital every Tuesday for MDT meetings and at other times during the week as required. Physical care was provided by a local GP. The consultant psychiatrist described a very good working relationship with the GP.

The provider tried to replicate a normal life as possible so in most cases patients attended the GP practice for appointments.

Weekend and out of hours medical psychiatric cover was provided by an on call consultant psychiatrist for the North East region. Incidents were automatically emailed to the doctor via the incident reporting system which meant they were aware of clinical events. The consultant psychiatrist confirmed that a doctor would be able to attend swiftly in the event of an emergency and gave an example of a recent call out of hours.

Compliance with mandatory training was above the provider's target of 80%. This included:

- Management of violence and aggression (Full) 97%
- Management of violence and aggression (Breakaway) 91%
- Safeguarding 98%
- MHA 97%
- MCA 97%

## Assessing and managing risk to patients and staff

We examined all seven care records and found risk assessments completed on admission and regularly updated. Risk assessments covered all potential risks and were particularly suited to patients with a learning disability. Six assessments were well written and detailed

# Wards for people with learning disabilities or autism

providing a clear overview of historical and current risks. Strategies and approaches to manage those risks were present. One risk assessment had duplicated information in each of the risk categories and was not of the high standard of the other records.

Staff were aware of, and able to describe the hospital policy for conducting patient observations. The emphasis of the policy was on meaningful engagement of patients in therapeutic and diversionary activities. For patients that were observed within eyesight or arm's length, staff were with them at all times during the day and were relieved if going on a break. The policy required an appendix sheet to be used for this recording which we did not see. However, during the day, progress was recorded in the daily records under 'my day care / activity' and also presented at handover.

Nursing staff were able to increase observation levels if needed but only a consultant could decrease levels of observations which safeguarded patients.

In the six months prior to our visit, there had been 188 episodes of restraint. None of these had been in the prone position which is when a person is held face down. The provider did not use the prone position when restraining patients and staff confirmed they were not trained in this technique. When talking about restraint, staff described how they would use talking and a low stimulus environment to try to avoid restraint being used.

Staff were trained in safeguarding and could describe how to make a safeguarding alert. They were aware of the different types of abuse and how they would respond if they needed to.

We reviewed all patient medication charts and found them completed correctly for all patients. A locked medicine cupboard was well arranged with appropriate labelling and was secured safely to the wall. There was a large amount of bottled medication for one patient with different doses. The reason for the high number of bottles appeared to have been due to decreases in the dose of the medication. We were concerned that there was an excessive stock of this medication. Excessive stock may risk patients being given the wrong medication and staff spending unnecessary time locating medicines.

We saw a medicine bottle which did not have the date it was opened on it. The instructions on the bottle were for it

to be disposed of within three months. It was good practice for medications with limited life after opening to have the date of opening written clearly on the container to help ensure it does not go past its expiry date.

The medicine policy did not advise staff what action to take if the label instructions differed from the medication chart. We saw in some cases that the medication dose written on the medication label did not always match the dose written on the medication chart. An example was an antipsychotic medication where the label on the medication said four tablets twice daily and the medication chart said three tablets twice daily. We saw another example of this with an anticonvulsant medication where the prescription on the medicine bottle differed to the medication chart. Staff told us that they always followed the medication chart and we were satisfied that patients were receiving their medications correctly as per the most recent prescription.

The provider was able to use the visitors room to accommodate children visiting following a risk assessment. However, wherever possible visits were encouraged to take place off the hospital site.

## Track record on safety

In the 12 months prior to inspection there had been seven serious incidents reported. Six incidents related to allegations of verbal or physical abuse of patients by staff members. One incident related to an allegation of abuse of a service user by a fellow service user.

All incidents were investigated by a director, consultant nurse or registered manager. Action was taken against one agency staff member. Care plans were put in place for all other incidents.

## Reporting incidents and learning from when things go wrong

All staff could tell us about the processes to follow for incident reporting. Staff knew what type of events needed to be reported and gave examples of physical interventions, allegations and aggressive behaviour. Support workers did not have access to the electronic incident reporting system. This meant they informed the qualified nurses of incidents and they would then enter the details onto the system. This could potentially lead to a delay in incidents being reported.

# Wards for people with learning disabilities or autism

We reviewed incidents in the incident reporting system and found them to be complete with full details of what happened and what actions took place after the incident.

There were no incidents that fell within the duty of candour requirements in the six months prior to our visit. The provider had a duty of candour policy and the electronic incident reporting system captured incidents which fell under the requirement. We observed that the system did not record psychological harm. All incidents were monitored monthly via the 'internal service review' process which meant senior managers were able to monitor that duty of candour procedures were being followed.

Some staff told us incidents were discussed with patients in the MDT meetings where triggers were identified to help prevent future incidents.

Staff told us they would be informed in handover meetings if an incident had occurred. We saw evidence of this in the handover records which included an overview of each patients presentation, any incidents and what activities patients had completed.

Staff meetings and supervision sessions were used to share learning and give feedback from incidents. Staff told us that de-brief sessions were offered but due to there not being many serious incidents, they could not recall the last de-brief session.

**Are wards for people with learning disabilities or autism effective?**  
(for example, treatment is effective)

Good 

## Assessment of needs and planning of care

At our last visit in August 2015 we were concerned that assessments of patients' needs were not comprehensive and holistic. During our latest visit we reviewed all seven patient care records and found they all contained comprehensive and timely assessments. Risk assessments and behavioural support plans were in place and all patients had the following up to date care plans:

- positive behaviour support plan
- physical intervention plan
- health promotion care plan

- Individualised specific care needs, e.g. epilepsy, as required medication
- and a meaningful activity care plan which provided an overview of patient's interest and activities.

Plans were clearly written and provided detailed instruction to ensure a consistency of approach by staff when working with each patient.

Records showed that a physical examination had been undertaken for all patients with ongoing monitoring of physical health problems.

Patients had a 'my day care plan' which was person centred and contained the patients care plans in picture format. Activity plans and timetables were patient centred and based on the needs and interests of the patient. This meant that they were effective in engaging and motivating patients. Daily records and MDT meetings contained reports of the patient's views.

We saw that patients received comprehensive occupational therapy, psychology and speech and language assessments where these were identified.

Each patient record also contained an MDT formulation and treatment plan which formed a formulation of patients' needs with a rationale for treatment. This provided further clarity of approach for staff.

When we visited in August 2015, we found limited assessments and planning of communication needs. Staff also lacked knowledge of effective communication methods. We saw improvements during our latest visit with individualised communication assessments and plans of care based on patients preferred method of communication.

The provider used paper care records which were stored securely in a locked cupboard. The records were accessible to all staff.

## Best practice in treatment and care

The Danshell group used a model of care called 'Personal PATHS'. The model was aimed at supporting people with complex needs in health and social care and was based on research and best practice. There were five key principles within the personal PATHS model: Positive behaviour support; appreciative inquiry; therapeutic outcomes; healthy lifestyles and safe services.

# Wards for people with learning disabilities or autism

Psychologists followed best practice guidance and used a range of rating scales and tools. These included the adaptive behaviour mood assessment and Glasgow depression and anxiety scale.

Occupational therapy assessments were carried out using the model of human occupation screening tool. Vocational questionnaires and sensory assessments were also carried out and we saw these in care records.

Health of the nation outcome scales for patients with learning disabilities assessments were completed to measure the outcomes of care and treatment.

All patients had a recent annual health check apart from one patient who had refused. We saw clinical observations in the care records for this patient.

## Skilled staff to deliver care

The provider employed staff in dedicated roles for occupational therapy, activities co-ordination, and psychology support. Pharmacy services were provided by a local pharmacist who conducted an annual audit. At the time of our visit, a sports co-coordinator was also employed. The provider did not have a dedicated speech and language therapist (SALT) and were trying to recruit. Referrals could be made for SALT assessment however, and we saw this happening in care records and during our visit.

When we visited in August 2015 we found that staff had had very little training in communication methods. At our latest visit we found that the provider had recently introduced Makaton training, which is a form of sign language, and autism training. Some staff we talked with had attended this training and we were shown future planned training dates for other staff. Talking mats, which is a picture communication aid, had also been implemented; however some staff told us they were concerned that there was still not enough alternative communication strategies.

All new staff received a comprehensive induction prior to taking up post. Support workers were inducted into the service using the care certificate standards. We talked with one support worker who had recently completed a four week induction programme and had been awarded the care certificate. The induction included a range of topics such as MHA, health and safety, learning disabilities, understanding client behaviours, how to calm and diffuse situations and physical interventions training.

Staff were required to receive a minimum of four managerial supervisions per year and six clinical supervision sessions. All staff told us they received regular supervision, often monthly. We reviewed two staff members' supervision records. A total of 88% of care staff had received an annual appraisal.

All staff had received training in positive behaviour support. Additional learning disabilities specific training had recently been identified such as dysphagia and epilepsy.

The consultant psychiatrist had an appraisal and revalidation in the past year.

## Multi-disciplinary and inter-agency team work

MDT meetings took place weekly and each patient was seen at least monthly. New patients were seen in the MDT meeting weekly for three weeks. MDT meetings were attended by all members of the multidisciplinary team. All members we talked to felt the MDT was effective and worked well together.

Handover meetings for staff coming on duty took place twice a day. We reviewed handover records which contained a 24 hour report of each patient's presentation and status. Incidents and changes to care and treatment were also discussed.

The registered manager reported good links with commissioners; however, commissioners did not often attend MDT meetings.

The hospital held daily "flash meetings" at 9.30am every day for indirect care staff including catering staff, activities co-ordinators and administrator. The meetings included a summary of which patients were going out, what activities were taking place in the hospital, what visitors were due that day (e.g. maintenance workers) and anything of significance in relation to patient's presentations.

## Adherence to the MHA and the MHA Code of Practice

When we visited in August 2015 only 5% of staff had received MHA training. This had increased significantly to 97% at our most recent visit. MHA training included awareness of the MHA code of practice.

We saw a list of policies which required updating following the revised MHA code of practice which came into effect on 1st April 2015. Several of the policies had not yet been ratified which meant that staff did not have up to date guidance to support them in meeting the requirements of

# Wards for people with learning disabilities or autism

the code of practice. Although we did not see any evidence that the principles and guidance of the code were not being implemented, we were concerned at the lack of progress with regards to updating policies.

Six of the seven patients were detained under the MHA and documentation relating to the Act was stored in a separate file. We reviewed all detention records and found them up to date and stored appropriately. Patients had their rights explained to them on a regular basis using easy read material. All patients had current capacity assessments. Ministry of Justice authorisation was present where appropriate.

Consent to treatment certificates, T2s and T3s were held with the medication cards and were found to be in order. We saw referrals to second opinion appointed doctors were made appropriately.

Patients were automatically referred to an independent mental health advocacy service and we saw evidence of independent mental health advocates (IMHA) in the patient's records. Patients and staff also said IMHA came to the hospital and found this service useful.

Section 17 leave forms were clearly written. Prior to activities outside of the hospital staff told us that section 17 forms were reviewed to ensure patients could attend.

Administration support and legal advice on implementation of the MHA and its code of practice was available from a central team. Staff knew how to contact this team and used them regularly for advice and training.

## Good practice in applying the MCA

When we visited in August 2015 only 10% of staff had received training in the MCA and DoLS. This had significantly increased to 97% at our most recent visit. Staff were able to tell us about how they would assess patients capacity and support patients to make decisions on a daily basis.

More complex assessments of capacity were discussed in the MDT and we saw evidence of mental capacity assessments for finance and medication.

One patient was subject to a DoLS authorisation at the time of our visit. We reviewed the records of this and found it to be in date and complete.

Advice and guidance for the MCA and DoLS was received from the central MHA department. All staff interviewed knew how to contact this team for support and advice.

## Are wards for people with learning disabilities or autism caring?

Good 

### Kindness, dignity, respect and support

Staff used caring and respectful language when taking about patients. We observed staff being polite and responsive whilst interacting with patients. We did however; see one staff member enter a patient's bedroom without knocking on the door first.

Staff had good knowledge and understanding of the patients care plans. Records and activity plans showed that staff considered patients' physical health and wellbeing. We saw plans in place for sports, weight loss and diet goals.

Patients described staff as "nice" and said the hospital was "a good place to live". Carers described staff as "very nice" "fine" and "caring".

### The involvement of people in the care they receive

On admission, all patients were showed around the hospital and oriented to the lounges and dining room during their first few days.

We saw evidence in care records of patient's involvement in their care planning and within MDT meeting minutes. We saw a notice board in a patient's bedroom with pictures which the patient used to show staff what they wanted to do for that week. If the patient changed their mind they could inform staff by changing the pictures.

Advocacy was provided to patients by an organisation called 'Voicability'. We saw information about advocacy services on patient information boards and saw evidence of advocacy referrals in care records. Some patients told us they had an advocate.

Independent mental health advocacy was provided by 'Rethink'. We saw that information on advocacy services were available and a notice board contained information on how to contact the CQC and make a complaint. Staff informed us that patients were supported by an advocate who attended their MDT meetings.

# Wards for people with learning disabilities or autism

Carers told us they were happy with the care their relatives received, however some told us they did not feel as involved in their relative's care as they had been at other hospitals. We had received similar feedback to this at our Visit in August 2015. Three carers told us they were always invited to MDT meetings but rarely attended as the hospital was so far away.

One patient told us that staff supported them to visit a family member every couple of weeks; this included them doing an activity together and going out for a meal.

Carers told us they mainly phoned the hospital for an update on their relatives care, stating staff only ring them if something happens. Not all carers spoke with their relative when they telephoned as they were often out or unable to come to the phone.

A newsletter for families and carers had recently been developed. We viewed the winter edition and saw the spring edition in draft. The aim of the newsletter was to inform relatives of any news and developments and to share the different activities that patients were involved in.

Patients were able to give feedback on the services they received through community meetings called 'house meetings'. Not all patients attended the house meetings and the registered manager explained that advocacy support is used to help patients who don't attend the meetings to provide any input to the meetings and MDT meetings.

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

(for example, to feedback?)

Good 

### Access and discharge

Patients were admitted to the hospital directly from the community, from a home environment, supported living or residential services due to an illness or a crisis in their life. They may also have come from a stay at a NHS or other specialist learning disability service, or following a

placement at a secure service. The average length of stay was now less than two years. When we visited in August 2015 a patient had recently been discharged who had been in the hospital for 14 years.

At our last visit the hospital had an intensive support suite. This had been closed by the time of our recent inspection. Any specific needs of patients were incorporated into individualised care plans.

Records we reviewed were recovery orientated and supported people to consider future moves. When we visited in August 2015 we found little evidence of discharge planning. At our visit in March 2016 we saw arrangements were in place to support people with discharge despite the challenges of finding appropriate placements. Staff we spoke with explained the difficulties they experienced with identifying suitable placements for discharge. Occupational therapy staff told us they focused on the aspirations of individuals through accessing therapeutic activities, education or employment to help prepare patients for discharge. We saw evidence of this in care records.

Three patients had received a care and treatment review. Transition arrangements and funding was being actioned following these.

### The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a range of rooms and equipment to support treatment and care. There were several rooms allowing for quiet time, socialising and therapies. These included a training kitchen, IT suite and beauty room. Patients could access the internet in the internet suite or with their own personal device. Staff supervision was available if required.

There were quiet areas and rooms available for patients to meet visitors in private and make phone calls. Patients had access to the hospital cordless telephone for making and receiving telephone calls in private. No patients currently had their own mobile phone but when we visited in August 2015 we saw that there were no restrictions on patients being able to keep their own mobile phones.

Some areas of the hospital had been arranged into an 'apartment' and one patient had their own en-suite bedroom, lounge and art room.



# Wards for people with learning disabilities or autism

Patients had access to pleasant outside space. Garden and side doors were not locked so patients could move around freely or with support from staff.

Patients told us they liked the food. We observed patients being offered food choices during meal times. These were presented in picture format so that patients who had limited verbal communication were able to express their choices effectively. One patient told us the female area had its own kitchen and the men did not. The patient said that this meant that female patients could make their own drinks but men would have to ask staff. Staff confirmed that all patients could have drinks and snacks 24 hours a day.

We saw patients' bedrooms were personalised and some patients could have their own bedroom key based on risk assessment. Bedrooms were locked so patients could securely store their possessions.

Patients received a good range of activities both in the hospital and outside of the hospital. These included art, IT, domestic and self-care skills, cooking, horse riding, wall climbing, swimming, cycling and walking. Staff ensured patients' interests were available in activities. An example of this was a patient who was interested in photography. This patient had regular trips out to take photographs which we saw displayed in their bedroom.

Carers told us they felt their relatives had plenty to do and were aware that their relative goes out of the hospital often. One carer told us they felt upset that they hadn't received a mother's day card and felt staff could have supported their relative to send one.

## Meeting the needs of all people who use the service

Adjustments had been made to the hospital to accommodate some level of disability. These included ramps, a lift and disabled bathroom and toilet.

At the time of our visit the provider had not needed interpreting services or material in a range of languages. We were informed that this was available if needed. We saw accessible information available for example, patients' rights and advocacy services. There were other leaflets and notices on information boards which were not accessible.

A dedicated prayer room was not available in the hospital. However, we were informed that a patient's religious and

spiritual needs would be met if they were admitted to the hospital as this would be assessed prior to admission. This included accompanying to church or providing time and place for prayer.

We saw a laminated notice on one patient's bedroom which said "when I am sad" and gave staff suggestions on how they would help the patient when they were feeling sad.

## Listening to and learning from concerns and complaints

We observed information displayed around the hospital on notice boards informing patients how to make a complaint. Staff told us how they would support patients if they did want to make a complaint. This included noticing that a patient's presentation had changed and asking them if something was bothering them. Staff also would help patients write a letter or raise it at the 'house meeting'.

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

Good 

## Vision and values

The organisation had a quality strategy 2016 which provided the vision, mission and implementation framework for improving quality across the organisation. The registered manager was aware of the organisations values.

Staff were aware who the senior managers in the organisation were and told us they visited regularly.

## Good governance

Monthly internal service reviews were completed by the registered manager and discussed with senior operational managers and directors. The reviews included key governance items including incidents, risk, clinical issues and audits. These helped senior managers check the quality of the service provided. The internal service reviews also helped the registered manager monitor progress and support staff in continuous improvement.

# Wards for people with learning disabilities or autism

Systems were effective in ensuring that staff received mandatory training as there was an electronic system in place to calculate and record training required and completed. This information was overseen by senior staff who could identify if any training was outstanding.

Staff received supervision and appraisals. We reviewed three staff records and found they contained appropriate employment checks. One 'disclosure and barring service' (DBS) check had expired and the staff member had completed a self-declaration form. A system was in place to ensure staff had repeated DBS checks as required and the reason this staff members had expired was due to a delay in it coming back.

Most shifts were covered by sufficient numbers of staff of the right grades and experience. We observed staff maximising their time on direct care activities.

There was a good awareness of incident reporting and knowledge of safeguarding procedures.

We reviewed the minutes of the unit led clinical governance meeting which were held quarterly. We saw a range of items discussed and monitored including care planning, evidence based practice, incidents and patient safety issues. A section of the meeting included a patient representative attending on behalf of other patients to provide feedback to the meeting.

We saw an issue raised by patients regarding the hospital minibus. Following this we tracked the issue being formally raised at the H&S meeting by the ward manager and we saw an action for this to be addressed.

The provider had nine items on the Danshell risk register. All items had controls in place and were monitored via the clinical governance monthly meetings.

We reviewed a number of audits including:

- MHA detention
- DoLS
- Confidentiality
- PRN medication
- Safer restrictive practices
- Clinical records

- Dysphagia
- CPA
- Physical health
- MCA
- Antipsychotic monitoring

Most audits had achieved the required pass mark; however safer restrictive practices, CPA and antipsychotic monitoring were below the pass mark. We saw actions clearly identified with follow up of these actions until they were completed.

## Leadership, morale and staff engagement

The average sickness rate for the ward over the past 12 months was 9%.

At the time of our visit there were no grievance procedures being pursued within the team and there was no allegations of bullying and harassment.

Staff told us they felt able to raise issues or concerns and would not hesitate to go to senior managers in the organisation. We saw evidence in incident reporting and email recording of concerns being raised and appropriate escalation and action being taken.

Staff reported the manager was a good manager and that they had a lot of operational support from senior managers. Staff said the team was a "great team", they "love it" and told us there was good retention of staff. One staff member told us it was hard work but "rewarding".

Staff reported good opportunities for training and a good MDT working relationship.

## Commitment to quality improvement and innovation

The provider had put in place an improvement action plan following the last CQC visit in August 2015. It was clear that improvements had taken place. In addition to this the provider had identified a number of focus areas for improvement. These included recruitment and retention, discharge planning, family involvement and training to ensure staff were able to meet the assessed needs of patients.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure the availability of equipment and medicines for use in an emergency.

### Action the provider **SHOULD** take to improve

- The provider should review its medicines management policy to ensure guidance is available for staff on how to manage discrepancies between the medicines labels and the prescription chart.
- The provider should ensure that medications with limited life after opening have the date of opening written on the container to ensure it does not go past its expiry date.
- The provider should ensure it does not hold excessive stock of medication.
- The provider should review access for male patients to make their own drinks.
- The provider should review its process for updating families and helping families visit their relatives.
- The provider should ensure that all appropriate staff attend specific learning disabilities communication training.
- The provider should ensure processes are put in place to implement and monitor changes and policies following the 2015 Mental Health Act code of practice.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <b>Appropriate equipment and medicines required in an emergency were not available.</b> This was a breach of regulation 12 (1) (2f)