Whorlton Hall Inspection August 2015- comparison of all versions of the reports

Please note the content in the table below has been taken directly from the five documents published, excluding the text in italics which provides a narrative comparison.

	Peer review of draft report 25/11/2015	Draft sent to report writing coaches 04/12/2015	Draft report post report writing coaches review 10/12/2015	Report ready for IM review 14/12/2015	Draft report post IM review 16/12/2015
Ratings	Safe – RI Effective - RI Caring - RI Responsive -RI Well led - RI	Safe – RI Effective - RI Caring - RI Responsive -RI Well led - RI	Safe – RI Effective - RI Caring - RI Responsive -RI Well led - RI	Safe – RI Effective - RI Caring - RI Responsive -RI Well led - RI	Safe – RI Effective - RI Caring - RI Responsive -RI Well led - RI
Safe					
Changes between versions	*This is the first version of the draft report that has been found from CQC systems*	*Summary has not changed from previous version* *The majority of the changes in the main text relate to sentence structure and use of words. Some points of evidence have been amended*	*Only change to summary is to sentence structure for three bullet points* *No evidence removed from the text of the main report. Some changes to sentence structure to make evidence clearer. Added two points where clarification was asked*	*Changes to summary in line with report writing coach comments* *This version of the report has no changes to the evidence presented in the first version aside from sentence structure in line with the feedback from the report writing coaches*	*Bullet point 3 of the summary amended* *This version has some comments seeking clarification and additional evidence and some changes to sentence structure in the main text but no comments on removing any of the evidence*
Summary for safe	• The safety of the external environment had not been adequately				

	assessed which meant patients, staff and visitors where placed at unnecessary risk of harm. • The hospital due to its layout did not have any clear lines of sight which meant patients could not always be overserved. • Where patients had clear plans in place regarding their observations staff were not completing relevant documentation or carrying out observations in accordance with patients care plans. • Ligature risk assessments had been completed. However, they did not contain any detail of how risks were managed. Patient records also did not record possible risks. • The service did not use a recognised tool to establish staffing levels and dependency of patients. We found there was not sufficient night staff to meet individual needs. We requested the				Staff were not completing relevant documentation or carrying out observations in accordance with patients assessed needs and care plans.

	provider send us a plan detailing how improvements would be made. • Mandatory training in regard to Mental Capacity Act, Mental Health Act and infection control was not adequate. • The service used a low stimulus room without any protocols or procedures for its use and essentially secluded patients without proper processes being completed. • The service had its own risk assessment tool; however, it was not being used in line with any formulated evidence based approach. Risk assessments were not regularly reviewed and agreed by the multi-disciplinary team. • Medicine policies were out of date. • There was no effective process in place to learn from incidents.				

Evidence from report	**Safe and clean environment** Reference to the large skip and that some patients were identified as potential to use items as a weapon. There was a lack of a risk assessment for this. Also glass and items in the garden. These concerns were brought to the attention of the manager who took action. No clear lines of sight so patients could not be observed unless directly by staff. Staff not carrying out observation in line with policy. Noted two patients left without supervision despite being known to assault each other. Unannounced visit on 5 Aug at night found staff eating in the kitchen and no staff with patients. Staff said the alarms would go off to notify them if a patient left their room. Patient rooms had no observation windows. Timed how long it took to response to an alarm, this took over 2	***Evidence variation from previous version*** **Safe and clean environment** A ligature risk assessment completed in July 2015 identified a number of concerns such as door handles and window openers. **Assessing and managing risk to staff and patients** Four members of staff told us patients were escorted to the room by staff and held in restraint on occasion unable to leave should they be in distress.	***Comment added by report coach against this section*** This is really complex and a bit wobbly because it's all ifs, buts, and maybes. It might be better to frame it in terms of; because the staff could not see who had left		***Comments to clarify the following*** **Safe and clean environment** Patient rooms did not have observation panels on the doors so staff could not maintain eyesight observation when a patient

	minutes for a patient that was meant to be on observations. We requested observation records for 5 August but not available staff said in each patient notes, this not in line with policy. Ligature assessment in 2015 with each to be manged locally, we found no evidence of this in-patient records. The service was clean aside from one bathroom that was not in use. **Safe staffing** 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 levels failed to meet the needs of patients effectively. For example, staffing had been set at five members of staff. One patient required five members of staff to de-escalate an incident should they become distressed		their room, or how many patients had left their rooms, it put patients at risk if one of those patients posed a risk to others. Bottom line is that the staff did not/could not observe patients as required on their records. The door alarms did not mitigate the known risks to patients who needed eyesight observation as noted on their records		was in their room with the door closed. No protocol was available to advise staff on how deal with this. Could staff describe how they dealt with this?

	A serious incident occurred in 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 the police needed to be called. No consideration had been given that incidents did occur during the evening. If all members of staff were occupied in the de-escalation of an incident then no staff members would have been available to manage the needs of other patients. Staff seen doing cleaning in the evening when patients required observations. Table containing overview of staffing numbers, vacancies and bank usage Staffing levels during the day usually consisted of one qualified nurse and eight support staff or sometimes two qualified nurses and seven support staff. Staffing		*Comment added by report coach* This is a very long and complex sentence containing lots of information. Do you mean: There 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		

	rotas confirmed each shift had the required number of staff. Mandatory training data • 10% of staff had completed training in Mental Capacity Act and deprivation of liberty safeguards. • 5% of staff had received training in mental health. • 36% of staff had received infection control. • 77% of staff had received training in equality and diversity. **Assessing and managing risk to staff and patients** Staff told us that the service did not have a seclusion room and this was something the service did not do A designated room referred to as “room 10” was presented to us as a low stimulus room. Staff told us patients were escorted to the room by staff and held in restraint on occasion unable to leave should they be in distress.		staff to manage the needs of other patients		

	The Mental Health Act Code of Practice defines seclusion as: “The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.” The code of practice equally states: Seclusion should not be used: ▪ as a punishment or a threat, ▪ as part of a treatment programme, ▪ because of a shortage of staff, ▪ where there is a risk of suicide or self-harm. We looked at eight incident records where the room had been used. There was no policy or guidance in place for the use of the room and equally no appropriate safeguards to ensure the				**Assessing and managing risk to staff and patients** 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. 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?

	room was used for its intended use In the previous six months there had been 129 incidents of restrain involving ten patients. None of the restraints were in the prone position The risk assessment tool used by the service was a “risk screening and assessment tool”. Danshell had not had this externally validated. This was not being used in line with the organisation methodology and staff had a poor understanding of its use. There were gaps in the risk recording and information was inconsistent and these were not agreed by MDT as per NICE. Staff demonstrated little understanding of autism, communication needs and recognised best practice. This contributed to a limited understanding of individual				in the previous six months, there had been 129 incidents of restraint involving 10 patients Was there a restraint policy? Danshell had not had this externally validated. Are we sure there was no external validation? Nurses completed the risk ratings and assessments. These were not agreed by the multidisciplinary team.

	needs, and as a result, there were high levels of restraint and restrictive practice to manage difficult and complex behaviour. The service managed medicines correctly. The organisation did not have any policy relating to rapid tranquilisation. This meant nurses had been administering drugs without any organisational guidance on the appropriate use. medicines management policy was due for review in July 2015, and was therefore out of date. The policy stated that two nurses were to sign for the administration of controlled drugs however, the service is often operating only one nurse per shift. Arrangements for protecting patients from abuse were in place. Staff knew how to raise				Were they discussed at review meetings? Staff demonstrated little understanding of autism, communication needs and recognised best practice. This contributed to a limited understanding of individual needs, and as a result, there were high levels of restraint and restrictive practice to manage difficult and complex behaviour We need to quantify this or take it out The medicines management policy was out of review date as it was due for review in July 2015. The policy stated that two nurses had to sign for the administration of

	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 in place with clear protocols for staff to follow. We did note in one patients records it stated where they made allegations against staff the first step was to “ignore” the allegation and escalate only if the allegation was repeated. There was no information detailing why the patient may make allegations against staff and how the patient was to be supported and protected. 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 were unsure how				controlled drugs but the service often operated only one nurse per shift. 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 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 More specific please

	they would protect themselves from abuse. **Track record on safety** From October 2014 until April 2015 the service had four serious untoward incidents • Two incidents involved patient on patient assault. • One incident involved allegations against staff. • One incident related to a patient in distress. **Reporting incidents and learning from when things go wrong** 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. Two patients told us they enjoyed the community meetings but did not always feel listened to when raising concerns about staff attitude towards them. Patients had made three allegations	*Evidence variation from previous version* **Reporting incidents and learning from when things go wrong**			Where patients abused each other, through violence or aggression, Do we mean assaulted?

	about staff conduct and behaviour. One of the allegations included one external organisations accusations regarding staff conduct and behaviour. None of the allegations were substantiated following internal investigations by the service. There was no evidence that learning from these incidents had taken place.	Patients had made five allegations about staff conduct and behaviour.			Nursing staff did not use any reflective tools after errors to improve practice or learn from the error. Do they need to use a 'tool' , was there reflection? The service demonstrated their openness and transparency to learn from their mistakes. How did they do this
Effective					
Changes from previous version		*The summary is the same as in the previous version of the report.* *Some evidence added to main text*	*The summary is the same apart from the inclusion of a 'however'* *Some evidence added and some removed. Overall very few remarks on this section of the report.*	*The summary is the same as the previous report.* *No other evidence changes from the previous report.*	*The summary is the same as the previous report aside from minor change to choice of word which did not affect the statements.* *A number of points to be clarified identified*
Summary			However		

	• None of the staff could tell us what treatment patients received except for medication. • There were no psychological treatments provided to patients with offending behaviours. • Patients did not always have health checks carried out in accordance with best practice. • Positive behaviour support plans did not include information regarding communication, sensory, and proactive strategies to manage complex needs. • Limited assessment of communication needs across the hospital and staff had limited knowledge in developing models for people using recognised tools. • No plans were in place regarding sexuality and sexual behaviour despite some patients having assessed needs in this area. • The service did not provide treatment and		• The service demonstrated improvement in staff supervision and appraisal • Staff attended team meetings • Mental Health Act documentation was in good order		

	care in accordance with best practice. • The quality of reporting of multi-disciplinary meetings was poor. Recording were not legible and no treatment plans were formulated. • The service did not meet the expectations of the Mental Capacity Act 2005 and despite identifying this within the own organisations audit no action had been taken to support staff till they had received training.				
Evidence in report	**<u>Assessment of needs and planning of care</u>** Patients did have health action plans and physical health care checks. Although we did find where patients were prescribed routine antipsychotic medication relevant checks had not always been carried out. Example of two patients where tests were done in 2013 but not again in 2014.	***Evidence added not in previous version*** **<u>Assessment of needs and planning of care</u>** Care model was that of personal PATHS. The principles of the model were Positive Behaviour Support • Appreciative Inquiry			***Comments to clarify the following*** **<u>Assessment of needs and planning of care</u>** It is encouraged that side effects of medication are discussed with patients and tools are used to capture this information. By whom?

	Mawdsley prescribing guidelines 2014. weight monitoring and blood pressure were present and were regularly being done It is encouraged that side effects are discussed with patients and tools are used to capture this information. There was no evidence this occurred and equally care plans did not contain any details regarding the side effects of medication and what nursing staff are required to observe. limited assessments and planning of communication needs across the hospital. Where patients had communication assessments in place staff failed to follow the plans and support patients effectively. One patient's preferred method of communication was the use of "talking mats". The patient had no talking mats available to use and staff had received no training in their use.	• Therapeutic Outcomes • Healthy Lifestyles • Safe services We asked during the presentation by the organisation for them 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. 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			***Change in wording from previous versions*** 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 Text from previous version • 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

	Staff didn't understand the purpose of the use of talking mats. Staff not using Makaton for a patient. Lack of care plans for addressing sexual behaviour and relationships despite this being identified as a need for some patients, and for others cognitive behaviour and oral health.	the community on the morning of our visit, and staff were unaware of the need for a risk assessment. They did not follow the care plan, which was in place to ensure patients received safe and appropriate care. Strategies and interventions had been provided by health professionals from other organisations relating to the management of sexualised behaviour and effective communication. None of the advice provided had been incorporated into a care plan and when we spoke with staff they were unable to tell us about the guidance provided or the strategies or interventions that should be used. This meant that important information for the care and well-being of people was not being followed. The Department of Health Guidance Positive and Proactive Care: reducing the need for restrictive interventions clearly sets out what the expectations are for caring and managing people			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". ***Text amended as follows*** 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". ***Clarification of the following points requested – these are highlighted in yellow***

		who have complex behaviours. Within the guidance it is detailed how services such as Whorlton Hall should incorporate positive behaviour support and the use of functional assessments as a core value for supporting people. The service did not incorporate elements of the guidance. The NICE Guideline in relation to Autism is directly relevant to the services provided at Whorlton Hall and this was not embedded within the service and there was little or no regard for them at all. When we spoke with a senior manager we were told that no audits had been carried out against the guidance to ensure the service was being responsive to patient needs. **Evidence added not in previous version** **Best practice in care and treatment**			• 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. 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? 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. So was there any SALT involvement or was it that it was not used?

	Best practice in treatment and care The service did not follow best practice and guidance in regards to the care and treatment for patients with a learning disability and/or autism	The service had not carried out any audits in relation to it meeting the expectations of the 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. Although medication was generally well prescribed with no patients being prescribed medication over the BNF Guidance the service did require 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 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 despite finding some areas for improvement such as further health monitoring where patients were prescribed medication that could affect their physical health.			
	Skilled staff to deliver care 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		***Evidence added not in previous version*** **Skilled staff to deliver care** We did see one example where a staff member's		**Skilled staff to deliver care**

	ensure staff worked in a consistent and collaborative manner. Some staff had training in communication methods. Staff demonstrated limited understanding of the importance of effective communication in both treatment and care, They did recognise this as an area for improvement. Staff did not have training for supporting people with MH needs. 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. Staff received no training in autism, this had been planned but not taken place. **Multi-disciplinary and inter-agency team work**	***Evidence added not in previous version*** **Multi-disciplinary and inter-agency team work**	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. ***Evidence in previous version but not present in this version*** **Multi-disciplinary and inter-agency team work**		Staff were not skilled to deliver effective care to patients Request to clarify_All care?? Or just PBS 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. So are we saying the training was tokenistic, insufficient, staff had not listened or taken it on board 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. So are we also saying they didn't know anything about it? Records suggested patients were not

	Patients were invited to weekly multidisciplinary team meetings The quality of the written multi-disciplinary notes review were poor because they were not easily legible and very brief. There was also no clear summary of therapeutic plan, no clear formulation, diagnosis or treatment plan 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** A Mental Health Act Monitoring visit took place in January 2015 where it was established patients were detained correctly under the Act. However patients weren't always informed of their rights.	There was equally no evidence of how clinical audits carried out influenced overall clinical practice. There were no clinical audits completed. We did note however that allied professionals such as occupational therapist and psychology had limited input to the service due to time allocation. Occupational therapy and psychology consisted of one and a half days.	We did note however that allied professionals such as occupational therapist and psychology had limited input to the service due to time allocation. Occupational therapy and psychology consisted of one and a half days.		progressing from the service until suitable placements were identified by their care co-ordinator Is this good bad or indifferent?

	<u>Good practice in applying the MCA</u> We were given a completed audit dated June 2015, which highlighted the service, was not meeting the expectations or requirements under the Mental Capacity Act 2005. It stated that patients were not effectively communicated with during the assessment and this affected any decision, which had been made. Eight staff we spoke to demonstrated a poor understanding of the Mental Capacity Act and the application of this	***Evidence in previous version but not present in this version*** **<u>Good practice in applying the MCA</u>** Patients with impaired capacity, their capacity to consent had been assessed without any formulated approach and without taking into account the . This had been documented in patient care records and was decision specific where necessary.			
Caring		*Changes to the summary with addition of 'howevers'* *Additional evidence added to main text of report*	*Changes to the summary from previous version* *No comments or changes to the main text*	*No change to the summary* *No changes to the main text*	*No change to the summary* *Change of wording in the first heading of the main text*

Summary	- Care plans were not person-centred because sufficient attention to patients communication needs had not been addressed. - Patients did tell us staff treated them with dignity and respect. - Patients did attend weekly community meetings where they were able to express their views of the service	- Care plans were not person-centred because sufficient attention to patients communication needs had not been addressed. However - Patients did tell us staff treated them with dignity and respect. - Patients did attend weekly community meetings where they were able to express their views of the service.	- There was limited information to show how staff supported patients with limited communication to make decisions about their care and treatment. However - Patients had access to advocacy services. - The service set up a family forum to involve family carers		
Evidence in report	**Kindness, dignity, respect and support** 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	*Additional evidence not in previous version of the report*			***Change of wording from previous version*** **Kindness, dignity, respect and support** 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 around with knowledge of how to engage the patient in conversation or how to work alongside him. A senior manager acknowledged what happened was both embarrassing and inexcusable. Staff spoke to patients in a kind and dignified manner and offered support and direction where needed. We observed one incident during the inspection where a patient became distressed. Staff supported the patient by in a compassionate and caring manner offering reassurance to minimise the distress being presented. **<u>The involvement of people in the care they receive</u>** The service had not addressed the communication needs of its patients adequately. People did not have detailed plans in place that would enable staff to follow key principles that focused on each patient's communication styles and	**<u>The involvement of people in the care they receive</u>** 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 the minutes of meetings that work had been			This led to an uncomfortable situation that the staff were unable to manage effectively.

	methods to ensure care was holistic and personalised The service had attempted to complete some person-centred plans however; these were incomplete for almost all patients and had little focus on increasing skill and independence. Plans had not been developed in line with how patients communicated other than some easy read templates, which was not suitable for all patients The service held weekly meeting with patients where they could discuss a range of issues that affected them. Example of an issues raised that was not addressed	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 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.			
Responsive					
Changes between versions	*Comment of now should or however in the summary.* *Comment on one section of evidence around a patient and NICE guidelines, this should be moved to another domain in the report. Subsequent versions of the*	*Summary changed to add 'however'* *Changes made in response to comments in main text*	*Suggests minor changes to wording of the summary* *No comments on the main text*	*Summary changed as suggested.* *The main text has not been changed*	*Summary wording changed from previous version* *Some questions for clarification and some changes to sentences structure but no change to the evidence in the main text*

	report showed this had been moved to Effective				
Summary for responsive	• The hospital admitted two patients to an intensive support suite but no admission criteria was established. • No patients had a discharge plan in place despite one patient being in the process of moving to a different service. • There was no evidenced based approach to analysing therapeutic based activities to ensure they were reflective of patient needs. • Patient's communication needs should have been adequately assessed and staff should effectively support patients to enhance their abilities. • The hospital optimised patient recovery. Patients had access to lounge	However • The hospital optimised patient recovery. Patients had access to lounge areas and leisure activities to support independence. • Patients told us they knew how to complain. The service had only received one formal complaint from a patient in over a year.	• The hospital admitted two patients to an intensive support suite, which had no established criteria • patients did not have a discharge plan despite patients being in the process of moving to a different service. • the service did not have an evidenced based approach to analysing therapeutic based activities, which made sure they reflected patient needs. • Staff did not complete environmental assessments regarding patient sensory deficits and mobility.		• The hospital had an intensive support suite which had no established criteria for admitting patients. Two patients had been admitted there. • Patients did not have a discharge plan. Some patients were in the process of moving to a different service. • The service did not have an evidenced based approach to ensure therapeutic based activities reflected patient needs.

	areas and leisure activities to support independence. • Patients told us they knew how to complain. The service had only received one formal complaint from a patient in over a year.		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.		
Evidence from report	**<u>Access and discharge</u>** 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	*Evidence not in previous version* **<u>Access and discharge</u>** The hospital reported that there had been one delayed discharge between 1 February 2015 and 1 August 2015 because the person			***Clarification of the following points requested – these are highlighted in yellow*** **<u>Access and discharge</u>** Pre-admission and admission assessments, risk assessments and

	ensuring that patients receive treatment in hospital for the minimum time possible. There was no admission criteria for the use of the intensive support suite and no protocol on what patients needed to achieve in order to move out of the suite. 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. Patients did not have a discharge plan in place, and senior managers recognised this as an area for development.	was awaiting an identified placement.			positive behaviour support plans were not individualised. Parts of these were repeated across patients care records as though text had been copied and pasted. 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 What best practice? 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. Was this within the hospitals control and/or what had they done about it. If nothing then we need to say.

	<u>The facilities promote recovery, comfort, dignity and confidentiality</u> The hospital was spacious with a variety of areas that patients could be engaged in activities. Patients appeared to regularly use a lounge area with facilities to watch TV and play pool. Patients did tell us they had access to computers with staff support. **<u>Meeting the needs of all people who use the service</u>** There was evidence of occupational therapy input which was based on a human occupational model(MOHO the activity records for each patient and found they engaged in a range of activities such as going to the shops, going for walks, horse riding, cooking and other leisure activities. Observation of a cooking session which was not	*Evidence not in the previous version* **<u>Meeting the needs of all people who use the service</u>** Staff told us patients could chose not to engage in activities and we saw evidence of this occurring, however there were no interventions or strategies with care plans to train and support patients in identified areas of need which would enhance their quality of life and support their recovery.			**<u>The facilities promote recovery, comfort, dignity and confidentiality</u>** Patients did tell us they had access to computers with staff support. Internet or just word etc? I think this was highlighted as good practice above so needs to be clear. Patients told us there were no restrictions in place for the use of phones and could use them when they requested Did they have a policy for use and how did they identify risks of their use? 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

	structured and the member of staff nor trained to deliver sessions to patients with complex needs. 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** they had received only one formal complaint within 12 months 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				This is an example of meeting the needs of the patients communication difficulty which has been criticised above
Well led					

Changes between versions	*Comments on the summary as follows:* All the potential positives here are worded negatively – need to decide if they are positive points and if so reflect them as such with more detail in the body of the report. *The changes suggested in the main text were linked to sentence structure and choice of wording.*	*Summary amended slightly in line with comments and a 'however' added* *Text in main section of the report changed in line with suggestions*	*Some suggestions on changing the wording in the summary* *One minor suggestion of change to wording in the text in the main section*	*Changes to the summary as suggested* *Minor change to wording in text made*	*Some changes to the summary suggested* *Most suggested changes are to sentence structure some comments asking for clarification of evidence*
Summary for well led	• Staff were not fully aware of the organisations visions and values. • Training in mandatory subjects was not adequate which placed patients at risk of not always having their rights upheld. • Staff supervision was improving, although was still not adequate. • The governance system in place although it was comprehensive the service had still not actioned key areas identified. • Staff did speak positively about the manager but	• Staff were not fully aware of the organisations visions and values. • Training in mandatory subjects was not adequate which placed patients at risk of not always having their rights upheld. • Staff supervision was improving • The service had not actioned key areas identified within its own governance systems. However • Staff did speak positively about the manager but described the overall staff	• Staff did not know the organisation's visions and values. • The service did not provide adequate mandatory training so patients were at risk because their rights were not protected • Staff sickness rates were high • The service did not take action on key areas identified within		• 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. • Staff sickness rates were high at 12%. • The service did not take action on key areas identified within its own governance systems. • Staff spoke positively about their manager

	described the overall staff morale as being "ok" with acknowledgement that it fluctuated.	morale as being "ok" with acknowledgement that it fluctuated.	its own governance systems. • Although staff spoke positively about the manager, 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.		but 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.
Evidence from report	**<u>Vision and values</u>** Staff with the exception of senior managers knew what the organisations vision and values were. The service had created their own version of vision and values and this was displayed on a wall, but				***Clarification of the following points requested – these are highlighted in yellow*** **<u>Vision and values</u>** We saw an outstanding action to complete which

	this was not a clear interpretation of the organisations vision and values. Team meeting minutes showed staff were informed of the quality strategy. The minutes of the meeting asked if units had reviewed and updated their Unit Transformation (Quality Strategy) Schedule. The minutes confirmed that Whorlton Hall management team still had not taken any action. **Good governance** The hospital was overseen by a clear governance structure operated by the Danshell group, which included an internal assurance system called quality development reviews. we saw recent audit findings from a Mental Health Act audit, a safer restrictive physical intervention and therapeutic holding audit and	***Evidence added not in previous version*** **Good governance** The unit had a risk register with clear actions in place to reduce risks occurring. However, the risk register did highlight 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, however at the time of the inspection these still remained unachieved.			was an environmental ligature risk assessment from February 2015.The assessment was completed in July 2015. So it was complete but late? Staff said the hospital manager was accessible and provided good support. How many?

	a deprivation of liberty safeguards audit. • All three audits fell short of the organisations pass rate and actions had been set. • We saw a recent infection control audit which had achieved the required pass rate. The unit had a risk register with clear actions in place to reduce risks occurring We were told of the process for ensuring all staff attended mandatory training and staff were able to tell us what they were still due to complete. Compliance with mandatory training was poor in some areas, such as mental capacity act and mental health act. **Leadership, morale and staff engagement** Staff reported the hospital manager was accessible and provided good support Staff described morale as "OK" "fluctuates" and "getting better". They felt able to				**Leadership, morale and staff engagement** Staff said the hospital manager was accessible and provided good support. How many?

	speak up and would go to higher senior management if the need ever arose Minutes were available from bi-monthly staff team meetings which showed a wide range of items were discussed. We saw areas for improvement from service reviews and incidents shared with staff, Staff told us they felt safe at work and that the team worked well together. We saw assessments of risk which ensured staff worked in pairs with some service users, however this was not always being followed 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				