Requires Improvement

Sussex Partnership NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
The Selden Centre	RX2Y6	Swandean Arundel Road Worthing West Sussex	BN13 3EP

This report describes our judgement of the quality of care provided within this core service by Sussex Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Sussex Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Sussex Partnership NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for Wards for people with learning disabilities or autism	Requires Improvement 
Are Wards for people with learning disabilities or autism safe?	**Requires Improvement** 
Are Wards for people with learning disabilities or autism effective?	**Inadequate** 
Are Wards for people with learning disabilities or autism caring?	**Requires Improvement** 
Are Wards for people with learning disabilities or autism responsive?	**Requires Improvement** 
Are Wards for people with learning disabilities or autism well-led?	**Requires Improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for LD inpatient facilities of **Requires Improvement** because

The service had blanket restrictions in some areas which were not based on individual risk assessments of the patients receving the service. These blanket restrictions affected the choices people were able to make about their care.

The male and female bedroom corridors were not fully separated as the door between the bedroom areas was open. This meant that men were able to walk freely into the female bedroom corridors. Even when this door was shut it was possible to see between the separate bedroom corridors which meant that people's dignity was not able to be maintained.

The service was using quiet rooms to seclude people that did not meet the standards of seclusion as written in the National Institute of Clinical Excellence and guidance from the Royal College of Psychiatrists.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires Improvement

We rated safe as **requires improvement** because:

There was a quiet room next to the main lounge which was, at the time of the inspection, being used as a seclusion room. This room did not meet the standards laid out in guidance from the National Institute of Clinical Excellence and from the Royal College of Psychiatrists.

There was a fire door separating the two sleeping areas and when we came onto the ward the door was propped open. This meant that males could directly access the female sleeping area and vice versa. There was confusion from the staff as to whether this door was normally kept open or closed. The interconnecting door had paper taped over the glass panel to restrict vision between the sleeping areas but the paper had been lifted in the corners. This was not considered to be an adequate and permanent way to protect privacy and dignity between the sleeping areas.

When we asked about health action plans, medical staff told us there were template books, but they were blank, they did not use them. The medical staff did not demonstrate an awareness of the importance of proactively considering physical health for people with learning disabilities. They told us they would refer patients to a specialist if a condition required it.

Are services effective?

Inadequate

We rated effective as Inadequate because:

Not all patient notes indicated that a physical health check had been undertaken on admission and some patients with ongoing health conditions did not have a health passport or health action plans that would accompany them if they needed additional health care input.

There was not a full multi-disciplinary team working on the ward at the time of our inspection.

We were told by medical staff that they did not assess capacity under consent to treatment provisions of the MHA. They did not appear to be aware of the requirement for this for people detained under the formal powers of the MHA. We were told that the medical staff had never assessed capacity to consent to treatment as the patients lacked capacity to participate in planning their care and treatment which had been judged informally without completing the required documentation.

Summary of findings

We looked at how patients were involved in decisions regarding their care and treatment and found that generic capacity assessments had been completed which were not time and choice specific and stated that all patients lacked capacity to participate in planning their care and treatment.

When we asked about health action plans, medical staff told us there were template books, but they were blank, they did not use them. The medical staff did not demonstrate an awareness of the importance of proactively considering physical health for people with learning disabilities. They told us they would refer patients to a specialist if a condition required it.

Are services caring?

Requires Improvement

We rated caring as requires improvement because:

When we came onto the ward we noticed on the lounge wall, several large white boards on which was written the name, section status, observation level and other confidential information relating to the physical nature of each patient's care.

Although the ward was introducing a communication strategy and some patients had had 'all about me' assessments completed, not all patients had had this.

We were told by several of the patients that they felt they did not get enough choice about what food they were receiving and that they were restricted from getting drinks from the kitchen and that this made them feel angry.

The care plans we reviewed were not signed by the patients or indicated that the patient did not sign and the reasons why.

Are services responsive to people's needs?

Requires Improvement

We rated responsive as requires improvement because:

The service did not have adequate discharge arrangements in place. Discharge was not routinely planned at the point of admission which meant it was unclear how long the intended stay was likely to be or what the longer term plan was for individual patients. The care records we reviewed did not all contain a discharge plan.

The physical environment was not conducive to patients' needs and the service was not focused on the promotion of independence.

There were blanket restrictions on the ward limiting patients' access to the garden, choice of meals and ability to access freely hot drinks and snacks.

Summary of findings

Are services well-led?

We rated well-led as requires improvement because:

It was clear staff were committed to working with patients with a learning disability and their enthusiasm showed through in their engagement with patients.

There was however a lack of clinical leadership and direction on the ward. We found that there was a lack of clarity of the treatment model being used within the service and although there was a clear service specification and operational policy for the service it was not being fully implemented.

The trust was gathering key performance indicator information, specifically relating to physical management within the Selden Centre and producing annual analysis reports, but it was not clear how this data was being meaningfully analysed and acted upon locally.

Requires Improvement

Summary of findings

Background to the service

The Selden Centre is a dedicated learning disability centre with the aim of supporting people back to community living. The purpose designed 10 bed inpatient centre provides care and treatment for men and women with learning disabilities who require expert intensive assessment, intervention and support.

Our inspection team

The team that inspected the Learning Disability (LD) inpatient services consisted of eight people: one expert by experience and their support worker, one inspector, one Mental Health Act reviewer, two nurses, a pharmacist, and one psychologist.

All eight people on the team visited the Selden Centre.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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 these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the ward at the Selden Centre and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the manager and deputy manager for the ward
- spoke with six staff members, including doctors and nurses

We also:

- Looked at five care and treatment records of patients.
- Carried out a specific check of the medication management on ward.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients told us there were restrictions on the meals they had on the ward, they had no choice of food and when to eat.
- Patients told us there were restrictions on when they could have a drink on the ward.
- We were told some staff were rude and controlling.
- Patients gave us mixed reports about feeling safe and happy on the ward but on the whole people did report feeling safe and happy.

Summary of findings

Some patients described feeling as if they were not being listened to and when they raised a concern they did not receive feedback**.**

Good practice

- We observed all interactions with people receiving the services to be orientated toward a life planning model.
- The services have a very pro-active approach towards referrals, which means people were seen quickly and receive the right care.
- We saw a variety of information available to people displayed in an easy to understand format.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve LD inpatient services

- **The need to remove blanket restrictions in some areas.**
- **Address gender segregation fully as the interconnecting door between the male and female ward was found to be open and even with the door shut it was possible to see between the wards.**
- **Address use of seclusion in a room not fit for purpose.**
- **The required documentation must be used to formally assess capacity to consent to treatment participate in planning their care and treatment which had been judged informally without completing.**
- **Capacity assessments must be completed which are time and choice specific in line with the mental capacity act.**

Sussex Partnership NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Unit	**The Selden Centre**

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.

The Mental Health Act reviewer made a thorough inspection of the facilities and environment, and observed staff interacting with patients on the ward. They reviewed the records of three detained patients, the individual seclusion records and the section 17 leave folders. An Expert by Experience and supporter interviewed three patients in private, and observed other patients being cared for.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were able to demonstrate a good knowledge and understanding of the Deprivation of Liberty Safeguards. However not all staff had received training which meant they were not always aware of their legal obligations.

We found patients had a blanket statement from the responsible clinician in their case notes saying that patients could not participate in planning their care. However these assessments were not time or decision specific.

Patients using the service had complex needs which often meant making difficult decisions regarding their care was not always possible without additional support. We looked at how patients were involved in decisions regarding their care and treatment and found that generic capacity assessments had been completed which were not time and choice specific and stated that all patients lacked capacity to participate in planning their care and treatment.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

By safe, we mean that people are protected from abuse and avoidable harm

We rated safe as **requires improvement** because:

There was a quiet room next to the main lounge which was, at the time of the inspection, being used as a seclusion room. This room did not meet the standards laid out in guidance from the National Institute of Clinical Excellence and from the Royal College of Psychiatrists.

There was a fire door separating the two sleeping areas and when we came onto the ward the door was propped open. This meant that males could directly access the female sleeping area and vice versa. There was confusion from the staff as to whether this door was normally kept open or closed. The interconnecting door had paper taped over the glass panel to restrict vision between the sleeping areas but the paper had been lifted in the corners. This was not considered to be an adequate and permanent way to protect privacy and dignity between the sleeping areas.

Our findings

Safe and clean ward environment

- The ward layout enabled staff to observe most parts of the ward. There were blind spots in the rooms being used as seclusion rooms which made the rooms unsafe to be used for secluding patients.
- Male and female sleeping areas were separate on the ward. All rooms had en-suite facilities and in addition patients had access to a separate male or female only bathroom and toilet facility. There was a fire door separating the two sleeping areas and when we came onto the ward the door was open. This meant that males could directly access the female sleeping area and vice versa. There was confusion from the staff as to whether this door was normally kept open or closed. The interconnecting door had paper taped over the glass panel to restrict vision between the sleeping areas but the paper had been lifted in the corners, this was not considered to be an adequate and permanent way to protect privacy and dignity between the sleeping areas.
- The ward was using a lounge next to the corridor as a female only lounge. The lounge did not have any signage indicating this room was for females only.
- All of the ward areas we observed appeared clean with furnishings in a good state of repair and the building appeared well maintained with good reporting systems to make sure any maintenance work was completed in as short a time as possible. The corridors were clear from clutter and people told us the standard of cleanliness was good.
- All staff carried alarms and there was a system for making sure the alarms were regularly charged and signed out.
- The ward had a full and thorough ligature audit that identified all of the ligature risks on the ward. This audit looked at all the risks associated with the potential ligature points and had plans in place to reduce these risks. The staff we spoke to were able to tell us how the risk assessment worked and the different approaches to minimise the risks.
- The clinic room was clean and tidy and all the clinical waste and sharps bins were correctly labelled and not over filled. We saw that the resuscitation equipment was regularly checked and the ward had good systems for day and night staff to make sure everyone knew whose responsibility it was to carry out the checks. Most staff had completed basic life support training and told us they were confident if they had to respond to a medical emergency on the ward.
- There was a quiet room next to the main lounge which was, at the time of the inspection, being used as a seclusion room. This room did not meet the standards laid out in guidance from the National Institute of Clinical Excellence and from the Royal College of Psychiatrists. It had no bed, no two-way communication system, no clear line of sight or mirrors, no toilet

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

facilities, and no visible clock. We requested that this room was not used for seclusion until adaptations had been made or an alternative room could be found that matched the standards.

Safe staffing

- The ward always had one registered nurse on duty and back up was available on an on-call basis to support the nurse. When we looked at the staff rotas for four weeks prior to our inspection, actual staffing levels were in line with the planned rotas. The skill mix was also taken into consideration when the rota was created. Regular nurses were being used from a nursing agency but only agency staff who were familiar with the ward could be used. Agency staff completed a two day orientation to the ward.
- The ward was able to obtain extra staff when the needs of patients changed and more staff were required to ensure the safety of the ward.
- People told us there was always enough staff on the ward so that patients could have their support to go into the community and a regular one-to-one discussion with their named nurse. Staff tried to organise escorted leave so that as many people as possible were able to go out and planned this in the diary.
- Staff who were trained in the use of physical interventions were not clearly identified on the rota. When we looked at the training records we could see that 90% of the staff had completed training to use physical interventions.
- The patients are not registered with the local general practitioner (GP) and we were told that the medical cover comes from the responsible clinician (RC) and via on call system with the local senior house officers (SHO).

Assessing and managing risks to patients and staff

- Observation of the patients was undertaken and staff were able to describe if enhanced observations were required, this was also enhanced by a good understanding of the needs of the patient group.
- We reviewed five sets of care notes and found risk assessments were in place for all patients but not consistently reviewed within the timeframe that had been stated or after every multi-disciplinary meeting had discussed an incident.
- When we reviewed patients' care notes we found that health passports and health action plans were not regularly used. Staff told us that information relating to physical health conditions could be found in communication folders. The communication folders we looked at confirmed this to be the case. The communication folders containing this confidential information relating to patients' physical health were found to be stored in the main lounge for ease of access and not in the office where the confidentiality of the patient group could be maintained. We could see that a system called Modified Early Warning Scores (MEWS) was used for checking physical health observations and the MEWS forms were being regularly completed by ward staff.
- When we looked at the care notes we found that when restraint techniques had been used, the staff were accurately recording the incident and restraint used in the notes and this was then discussed and minuted in the next multi-disciplinary meeting.
- Staff had received training in restraint and de-escalation techniques, and we saw evidence to support this.
- The ward had blanket restrictions around access to the kitchen, access to hot drinks, access to the secure garden. These were not always justified in individual patients' care notes and were not the least restrictive way of managing these risks for patients.
- There was a positive culture for supporting informal patients on the ward and they were able to leave at will, after letting the nurse in charge know. We noted there were signs on the doors out of the ward indicating this message.
- Staff were aware of how to make a safeguarding referral and had received training. However information was not available in an accessible format for patients with a learning disability and or autism, to inform them how to raise or report concerns about abuse.
- People using the service were not routinely provided with information about their medicines by medical staff. We observed medical staff discussing changes to a patient's medication regime and easy read medication leaflets and information were not used to support and guide the patient's understanding.

Track record on safety

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- In the trust reporting period from September 2013 to August 2014 there had been one unexpected death, two absconsions and one expected death within the Selden centre. This information was supplied by the trust but was later disputed. The trust state that there was only one absconsion during this time.
- Staff we spoke with demonstrated that they knew how to report and recognise abuse, felt confident in raising concerns and how they would escalate these if necessary. We were shown the electronic system used for the recording and reporting of incidents. All incidents were reviewed by the manager and the multi-disciplinary team (MDT). We saw evidence of how the Selden Centre then fed that information into the trust wide incident and alert administration teams to look at trends. We did not see evidence of how that data was then being used to affect change at a local level.

Learning from incidents and improving safety standards

- Staff had access to the trust safety alerts and resources on the intranet. They felt supported in reporting incidents and lessons learnt were discussed in both individual supervision sessions and in team meetings. We saw meeting minutes and supervision records and team and nurse meetings which confirmed this was done.

Are services effective?

Inadequate

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Are Inpatient LD services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as Inadequate because:

Not all notes indicated that a physical health check had been undertaken on admission and some patients with ongoing health conditions did not have a health passport or health action plans that would accompany them if they needed additional health care input.

There was not a full multi-disciplinary team working on the ward at the time of our inspection.

We were told by medical staff that they did not assess capacity under consent to treatment provisions of the MHA. They did not appear to be aware of the requirement for this for people detained under the formal powers of the MHA. We were told that the medical staff had never assessed capacity to consent to treatment as the patients lacked capacity to participate in planning their care and treatment which had been judged informally without completing the required documentation.

We looked at how patients were involved in decisions regarding their care and treatment and found that generic capacity assessments had been completed which were not time and choice specific and stated that all patients lacked capacity to participate in planning their care and treatment.

When we asked about health action plans, medical staff told us there were template books, but they were blank, they did not use them. The medical staff did not demonstrate an awareness of the importance of proactively considering physical health for people with learning disabilities. They told us they would refer patients to a specialist if a condition required it.

Our findings

Assessment of needs and planning of care

- Not all notes indicated that a physical health check had been undertaken on admission and some patients with ongoing health conditions did not have a health passport or health action plans that would accompany them if they needed additional health care input. We did see one good example of visual representations to help a patient understand an issue of consent in a health assessment but this did not appear to be consistent across the notes.
- Care plans were in place to monitor specific physical health needs but this was inconsistent across the sets of notes we looked at. None of the patients we asked had copies of their care plans in their rooms, but they had copies of their "all about me" book which had details about their physical health and communication needs in the lounge. These books were found to be written in a service user friendly and person centred way.
- The care plans we reviewed showed some evidence of a positive behavioural support (PBS) approach to supporting the patients based on functional assessments that had been done historically but this did not appear to be consistent across the notes.
- When we asked about health action plans, medical staff told us there were template books, but they were blank, they did not use them. The medical staff did not demonstrate an awareness of the importance of proactively considering physical health for people with learning disabilities. They told us they would refer patients to a specialist if a condition required it.

Best practice in treatment and care

- There was no information in patients' records to demonstrate the principles of Valuing People Now 2010 were being embedded in the service by engaging patients in meaningful activities that developed social inclusion or any of the principles of supporting patients with complex needs.
- Patients could access psychological therapies as part of their treatment and psychologists are part of the ward team.
- Some of the qualified staff on the ward had undertaken physical healthcare educational modules. This helped them keep an overview of the physical health needs of patients and ensuring physical health observations were maintained.

Are services effective?

Inadequate

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The ward used a system of modified early warning signs (MEWS) to identify physical health concerns. MEWS enabled staff to recognise when a patient's physical health was deteriorating or giving cause for concern and so trigger a referral to medical staff. Staff had received training in MEWS. The majority of MEWS scores had been calculated for patients.
- The ward multi-disciplinary team assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions. This was done regularly at multi-disciplinary meetings.

Skilled staff to deliver care

- There was not a full multi-disciplinary team working on the ward. The current team consisted of a locum consultant psychiatrist (two days a week), a psychologist, a speech and language therapist and a team of learning disability nurses.
- At the time of our inspection the ward had two qualified nurse vacancies and two support worker vacancies. The service also had a vacancy for an occupational therapist; this meant there was no occupational therapy service model or pathway to assess all patients currently in place. This meant that assessment and treatment plans relating to occupational therapy were not in place. The service was actively recruiting into these posts.
- All staff told us that they felt well supported by their peers and line managers. Staff were committed and motivated to provide a positive service for the people they worked with. We observed good team work and staff being respectful to one another. We saw evidence of regular individual supervision and appraisals and of monthly team meetings.
- Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role, including safeguarding children and adults, fire safety, life support techniques and the use of physical interventions. Records showed that most staff were up-to-date with statutory and mandatory training. We were also told by several support workers that they felt encouraged to be seconded into completing their qualified nurse training by the local management of the service.
- Most staff told us they received clinical and managerial supervision every month, where they were able to reflect on their practice and incidents that had occurred on the ward. There were regular team meetings and Qualified Nurse meetings and staff felt well supported by the manager and colleagues on the ward. Staff mentioned good team work as one of the best things about their ward.
- The medical staff did not demonstrate a clear view of the expectations of the care and treatment of the patients. When we asked them about treatment plans for the patients there was a lack of awareness of the leadership needed from the medical role in relation to the rest of the clinical team.

Multi-disciplinary and inter-agency team work

- Due to the needs of patients using the service we looked at how different communication systems were used in the service to engage patients effectively in decisions. We found evidence of alternative communication being used with patients who had little or no speech.
- Communication books were being used and had been individually tailored to patients. The ward had adapted versions of patient welcome packs and family/carer packs that had speech and language input to make them easy to read.
- The MDT met on a weekly basis to review the client care and this meeting was also attended by the ward pharmacist.
- Several patients told us that they did not see any health professionals outside of the Selden Centre such as opticians, dentists or GPs.

Adherence to the MHA and MHA Code of Practice

- Staff received training on the Mental Health Act and the Code of Practice.
- Information on the rights of people who were detained was displayed in wards and independent advocacy services were readily available to support people.
- Staff were aware of the need to explain people's rights to them. The explanation of rights was audited regularly on the ward. This ensured that people understood their legal position and rights in respect of the MHA.

Are services effective?

Inadequate

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- We were told by medical staff that they did not assess capacity under consent to treatment provisions of the MHA. They did not appear to be aware of the requirement for this for patients detained under the formal powers of the MHA. We were told that the medical staff had never assessed capacity to consent to treatment as the patients lacked capacity to participate in planning their care and treatment which had been judged informally without completing the required documentation.
- There was no evidence that patients or family members who accompanied them were being given a copy of their leave forms.
- Staff knew how to contact the MHA office for advice when needed and said that regular audits were carried out throughout the year to check the MHA was being applied correctly.

Good practice in applying the MCA

- Staff had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had also received regular emails from the trust about recent legal decisions on the MCA.
- Nursing staff had completed some full and thorough capacity assessments but this was not consistent across all the patients notes reviewed.

Requires Improvement

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as requires improvement because:

When we came onto the ward we noticed on the lounge wall, several large white boards on which was written the name, section status, observation level and other confidential information relating to the physical nature of each patient's care.

There was a communication strategy being rolled out but not all petients had the 'all about me' information sheets completed and these were found on a table in the lounge.

We were told by several of the patients that they felt they did not get enough choice about what food they were receiving and that they were restricted from getting drinks from the kitchen and that this made them feel angry.

The care plans we reviewed were not signed by the patients or indicated that the patient did not sign and the reasons why.

Our findings

Kindness, dignity, respect and support

- We spoke to five patients on the ward and while we were there we observed staff engaging with the other patients in a respectful and caring manner. Staff showed good understanding of the patients' individual needs.
- Patients we spoke with told us they felt safe on the ward and received good care, but that they did not always feel staff listened to them. We were told by several of the patients that they felt they did not get enough choice about what food they were receiving and that they were restricted from getting drinks from the kitchen and that this made them feel angry.
- When we came onto the ward we noticed on the lounge wall, several large white boards on which was written the name, section status, observation level and other confidential information relating to the physical nature of each patient's care, for example: "patient XXX has shingles". We pointed out to the staff that this was not respecting and maintaining the dignity of the client groups and this information was removed by the time we left the ward.
- We also found confidential material relating to patients on a table in the lounge.

The involvement of people in the care they receive

- When patients arrived on the ward they were shown around. There was also an easy read guide for patients giving them information about the service.
- The care plans held in the office were not consistently presented in an easy read format and it was not clear if the care plans were routinely adapted to easy read for the patients and that they were given a copy. The care plans we viewed were not signed by the patients or indicated that the patient did not sign and the reasons why.
- Details of local advocacy services were displayed in the ward.
- The ward held weekly community meetings with patients to gather their views about the ward. Minutes of the meetings were kept and they were displayed in an easy read format for everyone to see what had been discussed.

Requires Improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Are Inpatient LD services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as requires improvement because:

The service did not have adequate discharge arrangements in place. Discharge was not routinely planned at the point of admission which meant it was unclear how long the intended stay was likely to be or what the longer term plan was for individual patients. The care records we reviewed did not all contain a discharge plan.

The physical environment was not conducive to patients' needs and the service was not focused on the promotion of independence.

There were blanket restrictions on the ward limiting patients' access to the garden, choice of meals and ability to access freely hot drinks and snacks.

Our findings

Access, discharge and bed management

- The service provides support up to the point of discharge from the service. This means that a bed is maintained for patients even when the patients are on leave and while being reintroduced to a permanent residence.
- The service did not have adequate discharge arrangements in place. Discharge was not routinely planned at the point of admission which meant it was unclear how long each patient's intended stay was likely to be or what the longer term plan was for individual patients. The care records we reviewed did not all contain a discharge plan.

The ward optimises recovery, comfort and dignity

- The physical environment was not conducive to patients' needs and the service was not focused on the promotion of independence. This was demonstrated by the fact that patients did not access the kitchen and skills equipment was not available for patients to use. Patients had no individual timetable of activities that promoted independence and daily living skills.
- Patients had access to a lounge area with a television and a separate female lounge. In the reception area there was a visitors' room available for all patients.
- All bedrooms provided en suite accommodation, showers and toilets. The ward also had an accessible bathroom to support clients who preferred to have a bath.
- There was no telephone available in the ward area. Patients had to ask staff if they wanted to use the phone. The staff were then able to provide the patients with a cordless phone which we were told they were able to use in their rooms if they needed privacy.
- The ward offered access to a secure outside garden space, which included a smoking shelter. This area was surrounded by a 20 foot perimeter fence. This area was not freely accessible by the patients and the default position for the doors was locked which meant patients had to ask a staff member to open the doors to access the garden.
- There was a water fountain in the dining area and an area for patients to make hot drinks which was protected by a sliding screen, the default position for the screen was locked. This meant that patients had to ask staff members to open the hatch so they could access a hot drink. We were told this was a blanket restriction based on the risk presented by one individual patient.
- Patients were offered a choice of sandwiches at the lunchtime meal however choice was restricted at the evening meal to one option. We were told this was because the cook chill meals had to be booked six weeks in advance and it was difficult for some of the patients to cope with options of meals. We did not find this decision making process reflected in the care plans.

Meeting the needs of all people who use the service

- The ward was fully compliant with the Equalities act 2010. This meant the corridors were wide enough for a person in a wheelchair, with the appropriate ramps to enable access to all areas and an adapted bathroom.

Requires Improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- The ward notice boards had minutes from community meetings, information on how to complain, weekly ward timetables and access to advocacy.

Listening to and learning from concerns and complaints

- The complaints process was clearly displayed on the ward and was easy to access for patients with a learning disability. Patients told us they had complained to the ward manager and they were happy with the way it was dealt with.
- All the staff we spoke with were able to describe the complaints policy and how complaints were dealt with at local level. Staff tried to address patients' concerns informally as they arose.

Are services well-led?

Requires Improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Are Inpatient LD services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as requires improvement because:

It was clear staff were committed to working with patients with a learning disability and their enthusiasm showed through in their engagement with patients.

There was however a lack of clinical leadership and direction on the ward. We found that there was a lack of clarity of the treatment model being used within the service and although there was a clear service specification and operational policy for the service it was not being fully implemented.

The trust was gathering key performance indicator information, specifically relating to physical management within the Selden Centre and producing annual analysis reports, but it was not clear how this data was being meaningfully analysed and acted upon locally.

Our findings

Vision and values

- The ward staff showed an awareness of the wider organisation's values and the "better by experience" philosophy. However this was poor in comparison with the staff awareness of management at a local level.
- It was clear staff were committed to working with patients with a learning disability and their enthusiasm showed through in their engagement with patients.
- We were told that staff would probably recognise the chief executive but were not familiar with any other members of the board.

Good governance

- Governance work was being completed within the learning disabilities directorate and we were told about and saw minutes from the "quality rocks" meeting. Staff spoke very positively about feeling that governance structures were improving and they were able to input into that developing structure.
- The ward staff were actively participating in local clinical audits and they felt it was important to look at what they were doing and how they could improve.
- The trust was gathering key performance indicator information, specifically relating to physical management within the Selden Centre and producing annual analysis reports, but it was not clear how this data was being meaningfully analysed and acted upon locally.
- Ward staff we spoke with told us they were receiving the right amount of clinical and managerial supervision to meet their needs.

Leadership, morale and staff engagement

- At the time of the inspection the ward was being managed by the service manager as the ward manager was on maternity leave. The day to day running of the ward was being carried out by a newly promoted band six nurse.
- Staff reported they enjoyed working with their immediate managers and if they had any concerns they felt confident in raising them with their managers.
- Staff morale was high, there was a good team ethos and staff maintained good working relationships.
- There was however a lack of clinical leadership and direction on the ward. We found that there was a lack of clarity of the treatment model being used within the service and although there was a clear service specification and operational policy for the service it was not being fully implemented.
- The service has been running with a locum consultant psychiatrist for four years who was not trained appropriately to the services needs.
- Staff were aware of the whistleblowing process and would know how to use it if required.

Are services well-led?

Requires Improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff had access to leadership training and development. We saw examples of management training for middle management level and nurse secondment and career development being offered for support workers.

Commitment to quality improvement and innovation

- Staff we met demonstrated a good understanding of their aims and objectives with regard to their individual performance and learning.
- Monthly team meetings focused on team objectives and direction particularly through the implementation of new ways of working.
- The implementation of the "quality rocks" meeting was an active way of engaging the staff teams meaningfully in the process of quality improvement and staff we spoke to that were engaged in the meetings spoke very positively about it.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The trust did not ensure that service users were protected against the risks associated with unsafe or unsuitable premises. The service was using quiet rooms to seclude people that did not meet the standards of seclusion as written in the National Institute of Clinical Excellence and guidance from the Royal College of Psychiatrists. This was in breach of regulation 15(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The trust did not ensure that service users were protected against the risks associated with unsafe or unsuitable premises. The layout of the ward did not ensure that the privacy and dignity of service users was protected because there was not an adequate and permanent way to divide the sleeping areas of men and women on the ward. This was in breach of regulation 15(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Regulated activity	Regulation

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The trust did not ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The planning and delivery of care and treatment did not meet the service user's individual needs because there were blanket restrictions on the ward limiting patients' access to the garden, choice of meals and ability to access freely hot drinks and snacks.

This was in breach of regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.