Elysium Healthcare (Acorn Care) Limited

The WoodHouse Independent Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The WoodHouse Independent Hospital provides services for people with a learning disability or autistic people in a range of small, bespoke units and cottages. The service offers assessment, treatment and rehabilitation placements, individualised and intensive packages of care and step down to community-based services. The service specialises in providing care for autistic people and people with forensic histories.

We most recently carried out a focused responsive inspection at The WoodHouse Independent Hospital in October 2020, but we did not rate the location at this inspection. This meant we did not gather enough information across the whole service to re-rate it due to the specific focus of our inspection.

Following the inspection in October 2020, we issued an urgent Notice of Decision in relation to Regulation 12 regarding infection prevention control measures and placed conditions on the provider's registration. These conditions were removed in January 2021 after the provider applied to have the conditions removed and supplied evidence to us that infection prevention control practices had improved.

This inspection was carried out to follow up on the concerns identified during our previous inspection as well as respond to new information of concern received about the safety and quality of the services.

We undertook an unannounced focussed inspection of all key questions:

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

We visited the location on 8 June 2021 during the day and night shift and again on 9 June 2021 during the day shift.

We did not look at all key lines of enquiry during this inspection. However, the information that we gathered, the significance of the concerns and the impact on people using the service provided enough information to make a judgement about the quality of the care and enabled us to re-rate all key questions.

Our rating of this location stayed the same. We rated it as requires improvement because:

- People's care and support was not always provided in a well-furnished and well-maintained environment which did not always meet people's sensory needs.
- Not all staff understood how to protect people from abuse. Staff had training on how to recognise and report abuse but did not always know how to apply it

Summary of findings

- The service did not always have sufficient, appropriately skilled staff to meet people's needs and keep them safe. There was a high use of agency staff who did not always know the people they were supporting. There were not always enough nurses working across the site to support all eight units. Staff continued to not receive their break.
- Staff continued to not always follow systems and processes to safely prescribe, administer, record and store medicines.
- Staff did not always report incidents or carry out body maps after incidents of physical intervention.
- Not all staff working on the female unit Hawksmoor were provided with any additional specific training to support females.
- Maintenance faults were not always reported appropriately by staff and therefore were not rectified in a timely manner.
- People did not always receive kind and compassionate care from staff and they did not always understand each person's individual needs.
- Staff did not always receive regular supervision and the service had low rates of supervision.
- Staff did not always maintain contact and share information with those involved in supporting people, as appropriate. Relatives and carers did not always receive timely information and did not feel actively involved in planning their relative's care.
- There was not a robust system in place to ensure that staff who were working during the night shift were appropriately undertaking their roles.
- There were not always enough vehicles or drivers to support section 17 leave.
- There continued to be a lack of leadership at middle management level. Staff did not have confidence in nurse managers and did not find them approachable. Staff did not feel able to raise concerns without fear of retribution. The process in place for raising concerns was not always adhered to by managers.

However:

- People had their communication needs met and information was shared in a way that could be understood.
- People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- Care focused on people's quality of life and followed best practice. Staff used clinical and quality audits to evaluate the quality of care.
- People were actively involved in planning their care. A multidisciplinary team worked well together to provide the planned care.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.People were in hospital to receive active, goal-oriented treatment. People had clear plans in place to support them to return home or move to a community setting. Staff worked well with services that provide aftercare to ensure people received the right care and support in place they went home.
- People's care, treatment and support plans, reflected their sensory, cognitive and functioning needs.
- People were supported to be independent and had control over their own lives.

We expect Health and Social Care providers to guarantee people with a learning disability and autistic people the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people. The service could not show how they met some of the principles of right support, right care, right culture.

It was clear that there was a need for the service as agreed by commissioners. People were able to access the community for various activities and the service works towards policies and procedures being in line with best practice. Care that was provided to people was person-centred.

Summary of findings

However, the setting and design of the service did not always meet people's sensory needs. For example, we did not find Moneystone unit to be autism friendly. We also found with staff morale, staff cliques and lack of faith in managers, the culture was not always the right culture for people using the service.

We found a mixed culture at the service. We saw evidence that most recovery workers ensured people received person-centred care. However, we also heard about and saw evidence of some people being exposed to inappropriate practices and not always being protected from harm.

There was a lack of leadership at a nurse manager level. Staff were reluctant to raise concerns and when they did, managers failed to respond or act on these concerns. There were some poor relationships within staff groups and it was reported there were cliques among some staff across the service. This led to some staff reporting feeling uncomfortable working on certain units.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Requires Improvement 	The summary is contained in the overall summary at the beginning of the report. Our rating of this service stayed the same.

Summary of findings

Contents

Summary of this inspection

Background to The WoodHouse Independent Hospital

The WoodHouse Independent Hospital is an independent mental health hospital provided by Elysium Healthcare (Acorn Care) Limited. The hospital provides services for people with a learning disability or autistic people in a range of small, bespoke units and cottages. The service offers assessment, treatment and rehabilitation placements, individualised and intensive packages of care and step down to community-based services. The service specialises in providing care for autistic people and people with forensic histories; including sexual offending, highly complex and severe challenging behaviour. The service has recently refurbished Hawksmoor unit and reopened the unit to provide care and treatment to females. It provides care for up to 39 males and females under 65 years old who have learning disabilities or autism.

The WoodHouse Independent Hospital comprises of eight units located on a rural site in Cheadle, Staffordshire:

- Hawksmoor, female, five beds, locked rehabilitation with self-contained apartments;
- Lockwood, male, eight beds, locked rehabilitation unit;
- Farm cottage, male, three beds, open rehabilitation house;
- WoodHouse cottage, male, three beds, open rehabilitation house;
- Moneystone, male, eight beds, autistic people with complex or challenging behaviours unit;
- Whiston, male, four beds, autistic people with complex or challenging behaviours self-contained apartments;
- Highcroft, male, four beds, rehabilitation unit for autistic people;
- Kingsley, male, four beds, autistic people with complex or challenging behaviours self-contained apartments.

The WoodHouse hospital is registered to provide the following regulated activities:

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

At the time of inspection, there was a registered manager in place.

We most recently carried out a focused responsive inspection at The WoodHouse Independent Hospital in October 2020, but we did not rate the location at this inspection. This meant we did not gather enough information across the whole service to re-rate it due to the specific focus of our inspection. Following the inspection, we told the provider it must take the following actions to improve:

- The provider must ensure that staff adhere to infection control principles in line with the provider's policy and national guidance. (Regulation 12)
- The provider must ensure that staff working at the service adhere to the provider's policies and procedures. (Regulation 17)
- The provider must ensure that there are robust audits in place to monitor and improve the quality of care, with clear actions where appropriate. (Regulation 17)
- The provider must ensure that there is a robust system in place for staff to raise concerns, including verbal and written, without fear of retribution. (Regulation 17)

Summary of this inspection

We issued an urgent Notice of Decision in relation to Regulation 12 regarding infection prevention control measures and placed conditions on the provider's registration. These conditions were removed in January 2021 after the provider applied to have the conditions removed and supplied evidence to us that infection prevention control practices had improved. This inspection was carried out to follow up on the concerns identified during our previous inspection as well as respond to new information of concern received about the safety and quality of the services.

You can read our findings from our all of our previous inspections by selecting the 'all reports' link for The WoodHouse Independent Hospital on our website at: www.cqc.org.uk

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information. During the inspection visit, the inspection team:

- spoke with the registered manager and two nurse managers;
- spoke with or had feedback from 38 other staff members including; nurses, occupational therapist, psychologist, speech and language therapist, consultant psychiatrist and recovery workers;
- spoke with the local independent mental health advocate team;
- attended two handovers and one morning meeting;
- looked at 13 care and treatment records of people and;
- looked at a range of policies, procedures and other documents relating to the running of the provider.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with three legal requirements. This action related to one service.

- The service must ensure Moneystone unit has the equipment and furnishings to meet the sensory needs of the people on the unit. (Regulation 9).
- The service must ensure staff follow systems and processes to safely administer, record and store medicines. (Regulation 12)
- The service must ensure staff report all incidents, including the correct and appropriate information, and ensure body maps are completed in the event of any physical intervention being used. (Regulation 12)
- The service must ensure where the use of physical intervention is required, staff utilise approved techniques. (Regulation 12)
- The service must ensure there is a robust system in place that is adhered to, for staff to raise concerns, including verbal and written, without fear of retribution. (Regulation 17)

Summary of this inspection

- The service must ensure managers are visible and approachable for both staff and the people who use the service. (Regulation 17)
- The provider must ensure there are robust systems in place to ensure staff working during a night shift are appropriately undertaking their roles. (Regulation 17)
- The provider must ensure handovers contain sufficient detail to provide staff with the information they need to begin their shift. (Regulation 17)
- The service must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff working to meet the needs of people using the service. The staff must have a knowledge of the people they are supporting. (Regulation 18)
- The service must ensure all staff working on the female unit (Hawksmoor) are provided with specific training in supporting females. (Regulation 18).
- The service must ensure all staff, including agency staff, receive regular supervision in line with the providers policy. (Regulation 18).
- The service must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff working to allow staff to take uninterrupted rest breaks in line with the providers policy and working time regulations. (Regulation 18)

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure families and carers are provided with regular and timely information on their relative and are communicated with effectively. (Regulation 9)
- The service should ensure furniture is well maintained and fit for purpose. (Regulation 12)
- The service should ensure that infection, prevention control practices are embedded within practice. (Regulation 12)
- The service should ensure maintenance faults are logged appropriately and timely action is taken to resolve the faults. (Regulation 15)
- The service should ensure there are enough vehicles and drivers on site to facilitate people's section 17 leave and access to the community. (Regulation 18)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Overall	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

Requires Improvement

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate at this inspection.

Safe and clean care environments

Units were not always safe, well furnished, well equipped, well maintained or fit for purpose. However, all units were clean.

Maintenance, cleanliness and infection control

People's care and support was not always provided in a well-furnished and well-maintained environment. There were items of furniture on Lockwood unit that were ripped and needed replacing. On Moneystone unit there was boarded up glass in one of the doors and the door for the dining room was missing due to a recent incident. The environment on Moneystone unit did not meet people's sensory needs. The noise of the corridor echoed and there were no soft furnishings to minimise the noise. There were no sensory items noted on the unit except for a gym ball.

During our inspection we found the units to be very warm and uncomfortable to be on. Staff told us there were issues with air conditioning units not working properly. Following our inspection, the hospitals maintenance team and external air conditioning engineers reviewed all air conditioning units and found them to be working as they should. The provider reported it to be an issue with the knowledge of staff in operating the units about resetting them, the temperature and leaving windows open. Following the inspection, the hospital director sent correspondence to all staff and developed a guide in the use of air conditioning units.

We found staff did not always report all maintenance faults meaning some items were not on the maintenance log to be addressed. We found there was a fault with one person's shower which had not been working for a several weeks. Staff were aware of this, but it had not been reported to maintenance.

All unit areas were clean and cleaning records were up to date and demonstrated that units were cleaned regularly.

Infection prevention control procedures had improved. The majority of staff, with a couple of exceptions, were observed to be wearing their personal protective equipment correctly. Most staff were observed to sanitise their hands upon entry

and exit to a unit but there were also occasions when this was not observed. There were social distancing stickers and maximum room capacity signs on doors. There were donning and doffing stations located appropriately which were well stocked with masks, antibacterial gel and pedal bins. However, during our out of hours visit to site, CQC inspectors were not asked to produce results of a lateral flow test in line with the provider's policy and national COVID-19 guidance and were able to enter the units without evidence of a negative test.

Safe Staffing

The service did not have enough staff, who knew the people who used the service and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough staff who knew the people they were supporting. The hospital had assessed a staffing requirement of 26.2 whole time equivalent (WTE) qualified nurses and 185 WTE recovery workers. At the time of inspection there were 5.76 WTE nursing vacancies (22% of the provider's required workforce) and 51 WTE recovery worker vacancies (27.5% of the provider's required workforce).

We reviewed staffing figures from 10 March 2021 to 9 June 2021 and found that 30% of shifts were under the planned staffing numbers but were at or above the provider's assessed safe staffing figure. During the same period, there were 5.7% of shifts that were under the safe staffing figures required to support people's care and treatment. The safe staffing figure is the very minimum number of staff needed to support peoples care and treatment. If staffing falls below this, this can impact people's quality of care such as; not being able to go on leave or not being supported by the assessed number of staff required which could lead to an incident.

The service relied on agency and bank staff to fill shifts for any vacancies and sickness. For the same reporting period, 10 March to 9 June 2021, 71.6% of shifts had at least one agency member of staff working and 21.8% of those shifts consisted of 50% or more agency staff. Staff continued to tell us they were often unable to get their contracted 1.5-hour break during their shift due to staffing levels and prioritising people's leave. Staff told us this led staff to burnout and low morale.

We found not all agency staff had a high degree of understanding of people's needs or were able to provide care and support in line with people's care plans. People using and working in the service told us some agency staff did not always engage and interact with people when they were working. We spoke to an agency worker who was unable to tell us the name of the person they were carrying out observations for and was unable to describe that person's needs. Staff and people using the service told us this could lead to an increase in the number of incidents.

Staff told us there were cliques in some staff groups across the service in different units. This meant that some staff did not want to work on certain units where there were perceived cliques on. The service operated two different shift patterns, named Team A and Team B, and staff reported there were differences in the quality of staff between the shift patterns. People using the service also told us there were noticeable differences between the Team A and Team B shift on Hawksmoor unit and the way staff interacted with people. One team were perceived to put boundaries in place to support people's care and treatment, whilst the other did not. People told us this was inconsistent in supporting their needs and could lead to them having more incidents.

People received the correct medication, but this may not always be at the right time. Due to staffing levels, there was not always a nurse on each unit. Staff told us nurses would sometimes work and hold multiple keys for medication

cupboards across units. One nurse was shared across Lockwood unit and Farm Cottage and one nurse was shared across Highcroft and Woodhouse Cottage. Therefore, there would be six nurses scheduled to be working on the eight units across site. Staff told us this did not always happen and there were sometimes only four nurses working across the whole site to support eight units. This meant there was a lack of qualified leadership at unit level with recovery workers leading shifts. When reviewing staffing figures, we found there were a number of shifts where there were less than six nurses working across eight units. From 10 March to 9 July 2021 there were 25 shifts (13.6%) were there were only three or four nurses working across the entire site.

During our out of hours visit to the service, we did not observe staff to be sleeping but we continued to find staff relaxing in chairs who were startled when inspectors approached. Some units were in darkness without any lights on in the corridors. Staff were unable to provide a reason for this and it was not clear how they were able to observe people and record those observations clearly.

Assessing and managing risk to people and staff

Staff assessed and managed risks to people and themselves well. Staff had the skills to develop and implement good positive behaviour support plans. The ward staff participated in the provider's restrictive interventions reduction programme. However, there were some incidents where staff had used inappropriate restraint or holds on people which had resulted in avoidable harm.

Assessment of people's risk

Staff completed risk assessments for people on admission using a recognised tool and this was reviewed regularly, including after any reported incident.

Management of people's risk

People were involved in managing their own risks whenever possible. Staff anticipated and managed risk and we observed staff following people's positive behavioural support (PBS) plans to manage risk and support people who were distressed.

It was not always clear that staff understood the service's observation policy and the difference between support required as a package of care and enhanced observations. People had a package of care which detailed the number of staff they required to support them. Some people in addition to that had enhanced observations, requiring those staff to be with them at all times.

Use of restrictive interventions

The service monitored and reported the use of restrictive practices. They reviewed all reported incidences of restraint and used the examples as learning within their restrictive intervention's reduction programme. Incident reports were reviewed daily at the morning meeting. The service held a weekly incident analysis meeting to review the previous week's incidents across each unit to identify any themes or trends and develop actions and lessons learned.

During our inspection we reviewed people's records which demonstrated the use of restrictive practices should always be a last resort and saw evidence of care plans around the use of physical intervention specific to individual people's needs. We observed staff de-escalating people when they became distressed and one occasion, avoiding the need for the use of any physical intervention.

Requires Improvement

Wards for people with learning disabilities or autism

There had been several incidents where staff had used inappropriate restraint or holds on people which had resulted in avoidable harm. The provider had identified these incidents through their review of all reported incidents of restraint and taken the appropriate action following these incidents to keep people safe.

Safeguarding

Not all staff understood how to protect people from abuse. Staff had training on how to recognise and report abuse but did not always know how to apply it.

People were not always kept safe from abuse or avoidable harm. There were instances where people who used the service had unexplained marks on their body which were not known to staff how they occurred. This was not always reported appropriately or documented using body mapping at the relevant time. It was not always clear that staff understood how to protect people from abuse as they did not always report incidents appropriately.

Staff access to essential information

Staff had easy access to clinical information whether paper-based or electronic.

People's care records were accessible to staff, whether paper-based or electronic. All staff, including bank and agency, had access to the information they needed in order to support peoples care and treatment.

Medication management

The service had systems and processes in place to safely prescribe, administer, record and store medication, but did not always follow them.

Staff continued to not always follow systems and processes to safely administer, record and store medication. On Whiston unit we found one cream open without a date of opening or disposal in place, meaning staff could not be sure it was still effective when treating people. Additionally, there were some omissions in the recording of room and fridge temperatures on several units which meant staff could not always be sure that medications were kept within their specified temperature range. There were also omissions in signing for the administration of medications without a documented reason as to why. On Farm Cottage, an oxygen canister was stored in a locked cupboard next to flammable materials.

Staff used the principles of STOMP (stopping over-medication of people with a learning disability, autistic people or both) to only administer medication that benefitted people's recovery or as part of ongoing treatment. During our inspection, we observed that there was not a high use of anti-psychotic medication being used.

People's medications were regularly reviewed to monitor the effects on their health and wellbeing. People had a monthly multi-disciplinary meeting where medication were reviewed, and doctors were able to review medication when required at any point.

Reporting incidents and learning from when things go wrong

Requires Improvement

Wards for people with learning disabilities or autism

The service did not always manage safety incidents well. Staff did not always report them appropriately. Managers were not always able to investigate incidents and did not always share lessons learned with the whole team and the wider service.

The service did not always keep people and staff safe. Safety incidents were not always managed well as staff did not always report incidents appropriately. Staff did not always recognise incidents and did not always report them. When reviewing incident reports, we found details were not always correct and there were some important pieces of information not detailed within the reports. For example, one incident report did not detail a person's item of clothing falling down during a physical intervention and the measures put in place to protect privacy and dignity. Body mapping was not always completed following every incident of physical intervention, as required for safeguarding or in line with the provider's guidance. We found body maps were completed for a person during their support with personal hygiene but not consistently following any incidents they had.

We found lessons learned were not always shared effectively. The hospital had a lessons learned poster that was shared across site detailing previous experiences where things may have not gone to plan and highlighting changes and actions for the future. However, we did not see lessons learned shared during the handover of shift. During our inspection a person was very unsettled and required support from staff from other units, but this was not shared across site to support people and staff.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement at this inspection.

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of people who would benefit. They worked with people to develop individual care and support plans, and updated them as needed, but did not always work with relatives. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

Assessment of people's needs started at admission. Care and support plans were personalised, holistic, reflected people's needs and aspirations and were updated regularly. Care plans were goal orientated and had clear aims for people's care and treatment whilst at the service.

People and staff developed individualised care and support plans. We saw details of specific care plans such as physical health needs, sleepy hygiene, physical intervention and finance detailed within individual care plans, with input from various disciplines.

People had positive behavioural support plans in place which were detailed and clearly indicated how that person should be supported. We saw evidence of positive behaviour support plans referenced in incident reports and staff were able to describe different people's behaviours and ways to support them, as outlined in their plan. We observed staff following people's positive behaviour support plans to de-escalate behaviour during our inspection.

Requires Improvement

Wards for people with learning disabilities or autism

Staff completed functional assessments for people who needed them. They took the time to understand people's behaviours.

People were supported to be independent and have control over their own lives. People were encouraged to make their own choices and supported to have input into their care and treatment.

Some relatives and carers did not feel involved in the planning of care of their relative. We found some records detailed family and carer involvement whilst others did not.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported people with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

People had good access to physical healthcare and were supported to live healthier lives. The service had two physical care coordinators who facilitated people's physical health appointments, ongoing healthcare needs and supported with physical health observations. There were care plans in place for people's specific physical health needs such as diabetes and epilepsy. People were encouraged to eat healthily and were able to access fitness facilities in the community such as swimming.

People chose the activities they took part in. These were part of their care plan and supported people to achieve their goals and aid their recovery. People had individual timetables for activities. We saw details of baking in one person's care plan for a certain day and observed them getting ready for that activity during our inspection. The Occupational Therapy team provided a combination of group and one to one activity.

People's outcomes were monitored using recognised rating scales. Different disciplines used different outcome measures to assess people such as Health of the National Outcome Scale for People with Learning Disabilities (HoNOS-LD) and Modified Overt Aggression Scale (MOAS). Staff did clinical audit, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care. The psychology team were looking at new and innovative ways to engage people, such as through movement by having sessions whilst walking rather than more formally in a room.

People had access to a range of psychological therapies. Psychological therapies were offered to people based on their individual need and their preference, such as talking therapy or more formulation led therapy. Support with self-care and everyday living skills was available to people who needed it. Staff supported and encouraged people with cooking, shopping, personal hygiene to build independence for the future.

However, people who use the service and staff told us that there were not enough vehicles and drivers on site to facilitate section 17 leave and access to the community. We saw this on the day of our inspection where one unit was unable to facilitate section 17 leave without waiting for a member of staff from another unit to become available.

Skilled staff to deliver care

Requires Improvement

Wards for people with learning disabilities or autism

The unit teams had access to the full range of specialists required to meet the needs of people on the units. Managers did not always make sure they had staff with the range of skills needed to provide high quality care. They did not always support staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Staff received relevant training, including around mental health needs, learning disabilities and autism and conflict resolution. The service had a compliance rate of 94.4% for statutory and mandatory training. The provider told us staff received additional training in Makaton, Epilepsy and Diabetes. However, we found only 28.2% of permanent staff had completed this training. The provider told us new staff had been unable to complete this due to face to face training not taking place since March 2020 as a result of the COVID-19 pandemic. The provider told us staff had supported one another through peer support and additional aids to prompt staff were visible where training had been unavailable due to the pandemic.

In June 2020, Hawksmoor unit was refurbished and changed to a female unit having previously provided support to males. Staff who were working on the female unit had not all received training in supporting female people in their care and treatment. Staff told us when the unit first opened, staff were provided with the necessary training. However, since then, there has been no female-specific training provided to new staff members working on Hawksmoor unit.

Managers provided an induction programme for any new or temporary staff. There was a clear two-week induction programme in place for new starters. Permanent staff received an induction checklist covering their first three months of employment. Agency staff received an induction before working on site.

Some staff reported they did not always receive regular supervision in line with the provider's policy. Supervision rates at the time of inspection were low at 67.33%. Some staff told us they had carried out supervision with staff who they had not previously worked with or did not know very well. Agency staff told us they received supervision infrequently, with some reporting every six months.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. The unit teams had working relationships with staff from services that would provide aftercare following the person's discharge and engaged with them early on in the person's admission to plan discharge.

People were supported by a team of staff from a range of disciplines who worked well together to ensure care was delivered and outcomes achieved in line with care and discharge plans. The service worked towards a transdisciplinary approach and enhanced team working depending upon people's individual needs and preferences to provide a holistic approach to supporting people.

We observed the handover on two units during our inspection and did not find them to be detailed or of good quality. The information was brief regarding people's activities throughout the shift and did not include any significant information from other units, despite incidents occurring which affected the staffing on those wards.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Requires Improvement

Wards for people with learning disabilities or autism

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain peoples' rights to them.

Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff explained to people their rights under the Mental Health At in a way they could understand, repeated and recorded it clearly in their notes.

Staff stored copies of people's detention papers and could access them when needed.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity.

People were supported to make decisions about their care. Staff understood the Mental Capacity Act 2005. For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions. We saw detailed decision specific capacity assessments in place for people such as COVID-19, finance and sleep apnoea and evidence of best interests' meetings where necessary.

Are Wards for people with learning disabilities or autism caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement at this inspection.

Kindness, privacy, dignity, respect, compassion and support

Some staff did not always treat people with compassion and kindness or understand the individual needs of people. However, other staff respected peoples' privacy and dignity and supported people to understand and manage their care, treatment or condition.

People did not always receive kind and compassionate care from agency staff. The attitudes and behaviours from agency staff when interacting with people did not always show they were respectful and responsive. People did not always speak highly of agency staff, stating they did not always listen or engage and interact with them when working at the service and did not know their preferences. Additionally, there had been several incidents where staff had utilised inappropriate techniques when using physical intervention.

People were provided with advice, support and help when needed. During our inspection we observed staff interacting with people in a caring and supportive manner, particularly at times of distress.

Requires Improvement

Wards for people with learning disabilities or autism

We saw incident reports detailing where people's dignity was maintained during physical intervention. Staff supported people to understand and manage their care, treatment or condition. People spoke highly of permanent staff working at the service and the care they received.

Involvement in care

Staff involved people in care planning and risk assessments. They ensured that people had easy access to independent advocates.

Involvement of people who use the service

People were enabled to make choices for themselves and staff ensured they had the information they needed. They ensured people understood and controlled their treatment and support. We observed the use of communication aids to support people making choices and communicating their needs with staff.

People had easy access to independent advocacy. Staff supported people to maintain links with those that are important to them. During our inspection we spoke with the advocacy team who stated they had a good working relationship with service, received information in a timely manner and felt valued. During the COVID-19 pandemic, people were able to continue accessing the service as advocacy support was provided through video and teleconferencing.

People took part in making decisions and planning of their care. People were empowered to feedback on their care and support. They felt listen to and valued.

Involvement of families and carers

Staff did not inform and involve families and carers appropriately.

Staff did not always maintain contact and share information with those involved in supporting people, as appropriate. Relatives and carers told us they did not always receive information about people at the service and there was a lack of communication from the provider.

Are Wards for people with learning disabilities or autism responsive?

Good

Our rating of responsive stayed the same. We rated it as good at this inspection.

Access and discharge

Staff planned and managed discharges well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Discharges and transfers of care

Requires Improvement

Wards for people with learning disabilities or autism

People did not stay in hospital for a long time. People had discharge plans with clear timeframes in place to support them to move to a community setting or new provider, based on their individual needs. Staff liaised well with services that provide aftercare, so people received the right care and support when they moved on. People who used the service were able to describe their transition plans to their new provider to us and some people showed us their information book with photos of their new provider. We saw clear evidence of discharge plans in people's records.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and people could make hot drinks and snacks at any time.

Staff respected people's privacy and dignity. Each person had their own bedroom with an en-suite bathroom. People could personalise their room and keep their personal belongings safe. People had access to quiet areas for privacy. The service's design, and layout generally supported people's good care and support. However, furnishings did not always support people's care and support, particularly on Moneystone unit. People had access to fresh air via outdoor areas when they needed it.

The service provided people with a choice of good quality food. People could access drinks and snacks at any time. Some people had their own apartment with access to a kitchenette and were able to store their own food and drinks in their apartment. There were drinks in communal areas for people to access at their choice.

People's engagement with the wider community

Staff supported people with activities outside the service, such as work and education.

There were a number of real work opportunities available at the service such as maintenance, the shop, window cleaning and administration duties where people were paid to carry out these roles. The service was looking to develop more community-based work opportunities with the easing of restrictions from COVID-19.

Meeting the needs of all people who use the service

The service met the needs of all people using the service, including those with needs related to equality characteristics. Staff helped people with advocacy, cultural and spiritual support.

People's communication needs were always met. We observed staff utilising Makaton with people during our inspection to support their needs. People had access to information about their rights in appropriate formats.

The service worked to a recognised model of care for people with a learning disability or autistic people.

Each unit had a regular meeting for the people using the service where they were able to provide feedback on items they wanted for their units or things that could improve. People were also part of interview panels and a patient representative attended clinical governance meetings. There were surveys where people were able to feedback their experiences of the service.

Requires Improvement

Wards for people with learning disabilities or autism

Listening to and learning from concerns and complaints

The service treated concerns and complaints from people who use the service seriously. However, this was not the same for staff concerns and complaints.

People could raise concerns and complaints easily and staff supported them to do so. However, relatives told us that they did not feel as though they could. We saw evidence of complaints from people who use the service recorded, investigated and actioned and lessons learned shared with the wider service.

The service had introduced a process for staff to raise concerns and receive acknowledgement and feedback from those concerns. A whistleblowing tracker and complaints log were in place to record and monitor the process of complaints. We could not see evidence of lower level complaints, such as those raised verbally, documented on either the tracker or log and staff told us they did not always get a response when raising concerns. It was not clear that lessons learned from staff complaints and concerns were shared with the wider service.

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

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement at this inspection.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service or approachable for people and staff.

Not all nurse managers were always visible in the service or approachable for people and staff. Staff continued to tell us when some nurse managers visited the units, it was not for very long or to speak with staff and people.

Staff continued to tell us they did not find all nurse managers responsive to any concerns they raised. Staff reported emails being ignored or being told that concerns were being dealt with, without seeing any clear action or change. Some staff told us some nurse managers told them they were too busy to deal with their concerns.

Nurse managers had the knowledge and experience to perform their role but it was not always clear that they all understood the services they managed. There was no specific additional training for those staff moving onto the female unit. There had been issues highlighted with differences in the quality of staff affecting people using the service and units were not always autism friendly.

Staff spoke very highly of the new hospital director and found her to be approachable and responsive to concerns. Staff had noted there had been improvements in the running of the hospital since the new hospital director had come into post.

Vision and strategy

Requires Improvement

Wards for people with learning disabilities or autism

Staff knew and understood the provider's vision and values and how to apply them in the work of their team.

The provider's vision and values formed part of staff supervision for staff to give examples of how they had demonstrated them.

Culture

Staff did not feel respected, supported or valued. They could not raise concerns without fear.

Not all staff felt respected, supported and valued by nurse managers. Staff felt burnout with not receiving a break and the complexity of supporting some people on their unit. Staff told us they sustained injuries frequently at work and were not supported by ward managers. Whilst there were opportunities for career progression, some staff felt as though this was not always managed in a fair way. Staff told us sickness absences were taken into consideration and they did not feel as though experience and length of time at the service counted for progression. The provider told us attendance is one of multiple factors considered for progression and this is due to expecting senior staff to be a role model for junior positions. We reviewed five supervision records and there was no discussion around individual career progression detailed.

Staff did not feel able to raise concerns without fear of retribution. Some staff told us they felt they would be moved units or treated differently if they raised certain concerns. Others told us there was no point in raising concerns as nothing would be done. The provider told us staff would only be moved units in the event of safeguarding investigations or responding to concerns with staff cliques.

Governance

Our findings from other key questions continued not demonstrate that governance processes operated effectively at team level or that performance risk were managed well.

The service held monthly clinical governance meetings to monitor the effectiveness of governance systems and processes. However, our findings from the other key questions showed that governance processes did not always help to keep people safe, protect their human rights and provide good quality care and support. Staff did not always report or record incidents, staff concerns were not always recorded and responded to or lessons learned, body mapping was not always completed, and some agency staff did not appear to understand people's needs. Audits did not always work effectively to pick up concerns such as omissions identified in the administration of medication documented in medication charts.

Management of risk, issues and performance

Staff had the information they needed to provide safe and effective care.

They used information to make informed decisions on treatment options. People had regular multi-disciplinary meetings to review care and treatment.

Information management

The service engaged in local and national quality improvement activities.

Requires Improvement

Wards for people with learning disabilities or autism

People were able to develop and improve the service. People were part of recruitment panels, had community meetings to provide feedback and took part in surveys. Staff told us they did not feel as though they were able to do so as they did not feel valued, supported or that their voices were heard.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The environment on Moneystone unit did not meet peoples sensory needs.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Staff did not follow systems and processes to safely administer, record and store medicines** **Staff did not always report incidents, including the correct and appropriate information and ensuring body maps were completed in the event of physical intervention being used.** **Staff did not always utilise approved techniques when the use of physical intervention was required.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There was not a robust system in place that was adhered to for staff to raised concerns, including verbal and written, without fear of retribution.** **Ward managers were not always visible or approachable for staff and the people who use the service.**

This section is primarily information for the provider

Requirement notices

There were not robust systems in place to ensure that staff working during a night shift were appropriately undertaking their roles.

Handovers did not contain sufficient detail to provide staff with the information they needed to begin their shift.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Following the inspection, a warning notice was issued to the provider which told the provider areas which must be improved. In particular:** • Units did not have enough nursing staff of all grades to meet the needs of people. • There were a high number of staffing vacancies and a high use of agency staff. • Staff were unable to take regular uninterrupted breaks during their shift, resulting in staff burnout. • There were not enough nurses working across the site to support and lead the units. • Staff did not receive regular supervision and supervision rates were low. • Staff working on the female unit were not provided with any additional specific training to support females. • There were staff cliques on various units across the service which staff and people using the service told us.