Essex Partnership University NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Date of inspection visit: 6 to 8 November 2017
Date of publication: This is auto-populated when the report is published

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1LY3	Heath Close	Byron Court	CM12 9NW

This report describes our judgement of the quality of care provided within this core service by Essex Partnership University 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 Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of Essex Partnership University NHS Foundation Trust.

Summary of findings

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 found the following issues that the trust needs to improve:

- The ward layout did not allow staff to observe all areas of the ward. The staff could not view patient living areas from the ward office. Bedrooms were in corridors meaning staff had to be close to patients to allow accurate observation. However, we saw during our inspection that staff were regularly observing patients.
- Staff could not effectively manage patient behaviour and risk safely. The ward did not have seclusion facilities or a de-escalation area, which meant that staff used de-escalation and restraint in communal areas or patients' bedrooms. This could compromise patient's privacy and dignity.
- Managers provided data during inspection that there had been 80 incidents of restraint during the six months prior to inspection.
- Staff did not ensure that patients' care plans and risk assessments were regularly updated.
- The trust had not addressed some environmental issues identified at the last inspection in July 2017. The trust had not redecorated the communal living area, completed repairs and cleaned radiator covers.
  - The trust did not ensure all patients had safe furniture and furnishings to promote a recovery environment.
- Managers did not always debrief staff after incidents. This posed a risk of staff not feeling supported and not learning from incidents,
- Managers did not have sight of any trust targets or key performance indicators to monitor the performance of the team.
- Staff rotas for the month of October 2017 showed that there was insufficient staff to meet patients' complex needs on a daily basis.
  - Staff did not complete positive behavioural support plans with all patients. Five patients out of seven did not have positive behavioural support plans. There were plans in progress for other patients but these needed finalising.

However:

- Some actions from the last inspection were in the process of being addressed. Privacy screens had been applied to patients' bedroom windows, bedrooms had been redecorated, and specialist furniture for patients' bedrooms had been identified. Managers showed us a quote for purpose built wardrobes; they were awaiting approval from senior managers to order them.
- Managers had begun to train staff in positive behavioural support, 50% of staff had attended this training.
- Ligature risks were being managed effectively. Managers had updated the ward ligature assessment on 29 September 2017, which identified all ligatures points.
- Managers ensured that staff received regular supervision and appraisals. Staff told us the ward manager was supportive.
- There was effective multidisciplinary working both on the ward and with teams outside the organisation. Staff communicated regularly to formulate plans for patients that helped patients achieve their goals.
- We observed staff treated patients with kindness, dignity and respect. Staff were passionate about patient care and wanted to do their best to improve patient's experience.
- Patients were involved in writing their care plans and were given copies of them. Patients were involved in decisions about the service and had been involved in the recruitment of staff in the 12 months prior to inspection.

Summary of findings

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

Are services safe?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the trust needs to improve:

- The ward layout did not allow staff to observe all areas of the ward. The staff could not view patient living areas from the ward office. Bedrooms were in corridors meaning staff had to be close to patients to allow accurate observation. However, we saw during our inspection that staff were regularly observing patients. Staff did not store food appropriately. The fridge in the activities of daily living kitchen recorded high temperatures of nine and 10 degrees Celsius. Food may spoil at these temperatures leaving patients at risk of food poisoning. The Food Standards Agency recommends that fridge temperatures are no more than five degrees Celsius.
- Staff had not assessed or managed challenging behaviour effectively for all patients. Positive behavioural support plans were in place for only two of seven patients.
- Patients told us that escorted leave was sometimes cancelled due to lack of staff. We observed that one patient missed a dental appointment due to lack of staff whilst we were on inspection.
- The ward did not have a seclusion room. If patients needed seclusion, they were transferred to a psychiatric intensive care unit six miles away. On the day of inspection, we observed staff had difficulty locating an intensive care bed for one patient.
- Maintenance issues were outstanding from the last inspection. The problem with radiator covers being rusted and dented remained. The communal areas were still awaiting redecoration.
- The trust submitted data that showed that staff were overdue for mandatory training. Of the 14 staff who were eligible to undertake the training 46% had not completed manual handling training, 61% had not completed hoisting training, 47% had not completed restraint training. Only three of the five qualified staff had completed medicine management training,

However we found the following areas of good practice:

- The majority of ligature risks identified at our last inspection had been removed. Those that remained had been adequately assessed and the risk mitigated. Staff had access to photographic lists identifying ligature 'hotspot' areas for greater observation.

Summary of findings

- Staff carried pinpoint alarms, which they used to summon help in an emergency.
- The ward had a fully equipped clinic room with accessible resuscitation equipment and emergency medication that staff checked regularly
- 92% of staff had received safeguarding training. Staff knew how to make a safeguarding alert.

Are services effective?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following areas of good practice:

- Patients had care and treatment plans which were completed within 72 hours of admission.
- Staff supported patients to access annual health assessments. The trust had a health facilitation team, which followed up on patients' physical health checks.
- Patients had individualised activity programmes based on assessed level of need.
- Patients had access to behavioural therapy and speech and language therapy staff that carried out specific assessments. Staff developed easy read information for patients.

However:

- Managers had not ensured that staff were following best practice in terms of positive behavioural support (PBS) care planning for all patients. Whilst managers had started to train staff in PBS, only half the team had attended this training and only two of seven patients had PBS plans.
- Care plans contained minimal information. We found three out of seven care and treatment plans that staff had not updated following incidents. The impact of this was that staff might not be following the most appropriate care plan to meet patient need.

Are services caring?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following areas of good practice:

- We observed staff treating patients with kindness dignity and respect when interacting with patients.

Summary of findings

- Patients gave examples of how staff helped them, for example with their physical health needs and managing daily living skills such as cooking, cleaning and laundry.
- Care records demonstrated that patients had been involved in their care plans and patients confirmed this.
- Carers said staff invited them to attend multidisciplinary meetings; we observed that staff asked them for their views on the care.
- Patients had access to independent advocates.
- Patients gave feedback on the service at 'patient forum' meetings and morning meetings such giving their views and making choices about daily activities, individual time with staff and menus.
- Patients were involved in recent staff recruitment.

Are services responsive to people's needs?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following areas of good practice:

- For the last six months, the average bed occupancy was 83%. The average length of stay for patients was approximately three to six months; this was as would be expected.
- Prior to a patient's admission a telephone conference call was held with the multidisciplinary team, the commissioner and social care staff, to ensure admissions were appropriate to patient need.
- Staff sent weekly reports to commissioners with updates on patients, we also observed commissioners being present at a ward review meeting. Discharge plans were discussed at weekly reviews. Carers gave examples of being involved in discharge planning.
- Staff and carers said patients were offered 'easy read' versions of their care plans.
- The service worked closely with the intensive support team for learning disability and mental health who provided community support as an alternative to admission in the unit.
- The ward had a range of rooms to support treatment and care such as an activity room and an activities kitchen (separate from the main kitchen). There was also a designated room for visitors and an outside garden.
- There were suitable adjustments for people requiring disabled access including an assisted bathroom and bedroom.

Summary of findings

- Information leaflets were available in other languages for patients for whom English was not their first language. Information was also available in easy read format. This included information about treatments, patient's rights and how to complain.
- There was a designated chef on the ward and patients had a choice of food to meet their dietary requirements and could make individual requests.
- Patients knew how to complain and told us they would be supported by advocates if necessary.

However we found the following issues that the trust needs to improve:

- The service did not provide patients with secure places to store their possessions. Staff discouraged patients bringing personal belongings with them on admission, for this reason.

Are services well-led?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the trust needs to improve:

- At our last inspection, we identified concerns about the length of time the trust had taken to address risks identified for this ward. At this inspection, some works had been completed but there continued to be a delay in cleaning, repairing and maintaining radiator covers and redecoration of communal areas.
- Whilst managers were aware of national guidance for patients to have positive behavioural support plans and had begun to train staff in this model of care planning, they had not achieved their target of training all staff by October 2017. Consequently, not all patients had positive behavioural support plans care plans.
- The ward manager said they did not have sight of any targets or key performance indicators to monitor the performance of the team.
- Managers did not always debrief staff after incidents.
- Senior managers had not recruited to the deputy ward manager post, which meant that the ward manager was covering two posts. Staff were not aware if the trust had plans to recruit to this post.

Summary of findings

- Staff we spoke with felt senior trust managers did not have a good understanding of the problems faced by staff. In particular, patients' needs had increased over recent months. There was insufficient staff to take patients out for leave, or to enable staff to get breaks.

We also found the following areas of good practice:

- Managers had created a 'task and finish' group to meet monthly and have oversight of maintenance issues. The manager had ensured that the housekeeper had protected time every week to review the list of tasks for completion and liaise with the maintenance department.
- Managers had revised the ligature risk assessment. Potential risks were now identified, and the risk mitigated.
- Staff reported being passionate about their work and we saw that they were committed to delivering a good service for patients and staff said morale was generally good.
- Staff said there was good team working and they felt supported by their manager. They said they knew how to use the whistle-blowing process and raise concerns without fear of victimisation.

Summary of findings

Information about the service

Essex Partnership University NHS Foundation Trust was formed on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust and South Essex Partnership University NHS Foundation Trust.

Heath Close is in Billericay, Essex. Byron Court is a 12 bedded assessment and treatment unit located at Heath Close. In addition to seven commissioned beds, five beds are available for spot purchase by commissioners. It is a mixed sex ward for patients aged 18 years and over with learning difficulties or autistic disorder. It provides a service for informal/voluntary patients and patients detained under the Mental Health Act 1983. At the time of our inspection there were seven patients using the service.

This location was last inspected in July 2017 as part of a focused inspection of Essex Partnership University NHS Foundation Trust. This was in response to concerns received by the CQC about the environment and the management of patients. At this inspection we found breaches against regulation 12, safe care and treatment, regulation 10, dignity and respect and regulation 17, good governance due to the following:

- The trust had not ensured ligature risks were removed.
- The trust had not ensured the ward had safe furniture and furnishings for patients, which promoted a recovery environment.
- The trust had not ensured that the room used for seclusion was fit for purpose.
- The trust had not ensured patients had care plans for staff to follow to reduce the need for restrictive practices.
- The trust had not ensured its governance systems for assessing and monitoring the quality of ward environments were effective.
- The trust had not ensured ward maintenance actions were completed.
- The trust had not ensured patient's privacy was protected as bedroom windows were left uncovered.

At this inspection, we reviewed the trust's action plan to address these breaches and identified that the trust was making progress at addressing these issues. However, not all the breaches had been resolved within the trust time frames.

Our inspection team

Our inspection team was led by:

- Team Leader: Julie Meikle, head of hospital inspection, mental health CQC
- Lead Inspector: Victoria Green, inspection manager, mental health CQC

The team that inspected this location included two inspectors.

Why we carried out this inspection

This was an unannounced inspection to this location. Our monitoring highlighted concerns and we decided to carry out a focused inspection to examine these. These included concerns about the maintenance of the ward environment and staff's management of patients.

Summary of findings

How we carried out this inspection

We have reported in each of the five domains safe effective, caring, responsive and well led. As this was a focused inspection, we focused on specific key lines of enquiry in line with concerns raised with us. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report. We have not given ratings for this core service, as this trust has not yet had a comprehensive inspection.

During the inspection visit, the inspection team:

- conducted a tour of the ward at Byron Court and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the ward manager
- spoke with 14 other staff members; including doctors, nurses and student nurses, psychologist occupational therapist, administrative staff, housekeeping staff, the ward chef, pharmacist
- interviewed the associate director with responsibility for these services
- observed one hand-over meeting and one multi-disciplinary meeting
- looked at all seven treatment records of patients
- carried out a specific check of the medication management on the wards
- 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 gave examples of how they were involved in their care and how staff helped them, for example with their physical health needs and managing daily living skills such as cooking, cleaning and laundry.
- Patients said they could eat their favourite foods in hospital. A patient said staff encouraged healthy eating.
- Patients had a clear understanding of their care and discharge pathway.
- Staff invited carers to attend multidisciplinary meetings to discuss the patient's care. However, carers said that staff's communication with them could be improved, for example when a patient moved between wards.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure ward maintenance actions are completed in a timely manner to improve the quality of ward environment.
- The trust must ensure the ward has safe furnishings for patients, which promote a recovery environment.
- The trust must review its assessment and care planning process for managing challenging behaviour to ensure that all patients have positive behaviour support plans.
- The trust must ensure that staff are storing food in fridges below five degrees Celsius.
- The trust must ensure staffing levels are adequate to meet patients' needs.

Action the provider SHOULD take to improve

- The trust should ensure that staff are debriefed after incidents.
- The trust should ensure ward managers have sight of performance targets for their ward.

Essex Partnership University NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Byron Court	Heath Close

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

Our findings

Safe and clean environment

- The ward layout did not allow staff to observe all areas of the ward. The staff could not view patient living areas from the ward office. However, we saw during our inspection that staff were regularly observing patients.
- There were ligature risks in areas of the ward such as the assisted bedroom, assisted bathroom and therapy room. These were identified on a ligature risk assessment dated 29 September 2017 and were in areas where patients were observed at all times.
- The ward was compliant with guidance on same sex accommodation.
- The ward had a fully equipped clinic room with accessible resuscitation equipment and emergency medication. There was evidence that emergency medication and equipment had been checked regularly.
- The ward did not have a seclusion room. The trust has submitted plans to create a seclusion and de-escalation suite. If patients needed seclusion, they were transferred to a psychiatric intensive care unit six miles away.
- The trust had not addressed the following issues from the last inspection. The problem with radiator covers being rusted, dented and in one case, smelling of urine remained. The communal areas were awaiting redecoration.
- Other areas of the ward were clean and well maintained with many of the issues of the last report having been resolved. Managers had delegated the responsibility of checking up on maintenance issues to the housekeeper, who kept a running log of all maintenance. These issues were also followed up in a monthly task and finish group. Since this arrangement had been in place, all patients' bedrooms had been repainted and the electric sockets that were damaged had been replaced or blanked off. Maintenance staff put privacy film on patients' bedroom windows on the day we inspected.
- Cleaning records were updated daily, and we observed housekeepers cleaning the ward during inspection.
- Staff were not storing food appropriately. The fridge in the activities of daily living kitchen recorded high temperatures of 9 and 10 degrees Celsius. Food may spoil at these temperatures leaving patients at risk of food poisoning. The Food Standards Agency recommends that fridge temperatures are no more than 5 degrees Celsius.
- Staff carried alarms, which they pulled to summon help when dealing with incidents. These were observed to be working on the day on inspection.

Safe staffing

- Whilst the establishment figures provided by the trust indicated sufficient staffing, when we reviewed staff rotas for October 2017 staffing was insufficient to meet patient need.
- The establishment was six qualified including the ward manager and seven healthcare assistants. There was a vacancy for a band six nurse and a band three administrator.
- Managers told us they relied on bank and agency staff to cover shifts on a daily basis. To provide consistency and continuity, these trust bank staff knew the ward.
- The ward manager was able to adjust staffing levels daily in response to the patients' needs but told us it was often difficult to find staff at short notice. The manager was often counted in ward numbers meaning that it was difficult for them to fulfil their managerial duties.
- Trust data showed that the ward staffing levels met their target of 90% staff fill rate from April to August 2017. However, for October 2017 this had not been the case. We reviewed four weeks staff rotas from 2 October to 30 October 2017, which showed that the ward was short staffed on 15 days. This included 13 qualified shifts and 8 unqualified shifts. Trust data from August to October 2017 showed a total of 390 hours for registered nurses and 217.5 hours for healthcare assistants, which had been unfilled. This equated to 31.2 qualified staff shifts and 17.4 healthcare assistant shifts. Staff told us that they frequently did not get a break particularly during night shifts.

Are services safe?

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

- A senior manager had completed a nursing establishment review report in July 2017 with a bid to request additional staffing. Information was due to be submitted to the senior management team meeting on 29 November 2017.
- There was adequate medical cover for the ward. There were three consultant psychiatrists and a staff grade psychiatrist providing 24-hour cover to the ward meaning a doctor could attend the ward quickly in an emergency.
- Escorted leave was sometimes cancelled due to lack of staff. Patients and staff confirmed to us that leave for one patient was cancelled during our inspection due to a lack of staff.
- The trust submitted data that showed that staff were overdue for mandatory training. Of the 14 staff who were eligible to undertake the training 46% had not completed manual handling training, 61% had not completed hoisting training, 47% had not completed restraint training. Only three of the five qualified staff had completed medicine management training.
- For the months of September 2017 and October 2017 staff sickness was 19.8% and 25.8% respectively against a target of 4.5%. Managers told us there were two staff on long term sick which accounts for this high percentage against a small staff team.

Assessing and managing risk to patients and staff

- Staff had not assessed or managed challenging behaviour effectively for all patients. Positive behavioural support plans were in place for only two of seven patients.
- In the last six months, the service reported 80 incidents of restraint. Only one of these was prone restraint. Prone restraint is where the patient is restrained in the chest down position and should be avoided wherever possible.
- Since the last inspection, with the exception of one incident, which was quickly discontinued, staff did not seclude patients on the ward.
- Restraint was only used when de-escalation techniques had failed. Staff were meant to be trained in therapeutic and safe interventions and used these techniques to restrain patients when necessary. However only 53% of staff were up date with this training.
- If seclusion was necessary, staff transferred patients to the local psychiatric intensive care unit, which was six miles away. Managers had developed a plan to have a de-escalation and purpose built seclusion room, this was awaiting approval.
- Staff did not always update patient risk assessments following an incident. We looked at seven care records which all contained risk assessments. However, three of these had not always been updated following incidents, and five care records did not contain positive behaviour support plans in line with national guidance.
- The ward was locked and staff assured us that informal patients could leave at will. We saw informal patients leave during our inspection.
- There were policies and procedures for staff observation of patients. Staff reviewed patients' observations daily and searched patients when they returned to the ward on an individual care planned basis.
- Staff had used rapid tranquilisation twice in the last six months. We saw evidence in patient records that it had been used in accordance with National Institute for Health and Care Excellence guidelines.
- Following a recent patient safety alert around the use of sodium valproate in pregnancy, the trust had developed an action plan and had sent a medicines management newsletter sent to all staff in May 2017. However, the staff were not aware of this.
- 92% of staff had completed level two safeguarding training, however only 50% of qualified staff had completed the required level three safeguarding refresher training within the three-year period. Staff knew how to make a safeguarding alert. Staff told us they had good links with the trust safeguarding leads and the local authority and could use these to seek advice if needed.
- Staff managed medicines well. We inspected the clinic room and saw that there were effective medicine management practices. There was safe and appropriate

storage and dispensing of medications. Patients handed over their medication to staff on admission and staff supported their medication concordance from then until discharge.

- There were safe procedures for children to visit. Children were not permitted in ward communal areas but were able to visit in a specific room where there were toys and activities provided.

Track record on safety

- As this was a focused inspection, we did not request specific data about the number of serious incidents for this core service since April 2017. However, managers told us there were no serious incidents reported by this ward over the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff knew what situations required reporting as an incident. The trust used electronic recording systems to record incidents and staff knew how to use the system. Staff were open and transparent and explained to patients and their families and carers when things went wrong. We observed this in a ward review, and in care records. However, a carer also informed us that there had been a delay in notifying them when their relative was admitted to a general hospital for physical health needs.
- Staff discussed incidents and feedback from investigations during team meetings. However, managers did not provide staff with de briefs following serious incidents.

Are 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.

Our findings

Assessment of needs and planning of care

- Staff completed care and treatment plans within 72 hours of a patient being admitted to the ward.
- We found staff had not updated care plans following incidents. One record contained language that was not patient centred or recovery focused, stating that the patient had "agreed to behave". This did not show that the staff understood the function of the patient's behaviour but rather read as though the patient had agreed to conform to the rules of the ward.
- Care records showed that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems. The trust had a health facilitation team that followed up on patients' physical health checks.
- Staff used the trust's electronic patient record system for recording information.

Best practice in treatment and care

- Managers had not ensured that staff were following best practice in terms of positive behavioural support (PBS) care planning for all patients.
- Managers showed us training records that demonstrated that 50% of permanent staff had recently attended training in PBS. The trust had identified in its action plan dated 17 October 2017 that staff would have completed a "bespoke training package" in PBS by October 2017 but had not fulfilled this. We spoke with the behaviour therapist for the ward who told us that care plans were currently based on the antecedents, behaviour, and consequences model and that she was working to audit and update these to PBS plans. At the time of inspection, two of seven plans had been updated.
- There was evidence that staff followed best practice in prescribing medication in accordance with National Institute for Health and Care Excellence (NICE) guidelines
- The team had access to a behavioural therapist and two part time psychologists whose time was shared with the community learning disability team. This enabled access to the NICE recommended psychological therapies. However, staff told us psychologist's allocated time was not sufficient to pick up new referrals from the ward in a timely manner, meaning that new referrals were waiting up to a year for therapy. In some cases, patients had been discharged back to the community before commencing therapy.
- Staff generally provided access to physical healthcare, and when necessary, staff facilitated transfer of patients to physical healthcare appointments. However, we observed during inspection that staff were unable to support a patient to a dental appointment due to insufficient staffing levels.
- Patients at risk of choking had specific 'soft' or 'mashed' diets in place. The chef and the speech and language therapist worked together on how to prepare meals for patients. Patients had protected mealtimes to allow staff to support patients as required with eating or drinking. Patients said staff encouraged healthy eating.
- Staff developed easy read information for patients such as for advanced directives, 'my choices', and dysphasia. Staff used a document 'all about me' with patients, which detailed the best way staff, should communicate with them. Other examples of developments were social stories and medication plans.
- Staff use recognised rating scales to assess and record outcomes for example the model of creative ability tool, activity participation outcome measure and the health equalities framework outcomes measurement for learning disabilities.

Skilled staff to deliver care

- The ward had access to the full range of disciplines to support patient care; we observed that an occupational therapist, physiotherapist, social worker, nurses, and consultant psychiatrist attended ward reviews. The trust pharmacist visited the ward weekly.
- Bank staff workers were given supervision and invited to unit training sessions. New staff had a trust and ward induction, and two newly qualified staff nurses were completing a preceptorship programme.
- Nurses were trained to work with patients with a learning disability. Examples of specialist training included autism and sensory awareness. The psychology team had recently delivered autism awareness training to all permanent staff. A senior

occupational therapist had completed sensory integration training. The manager said they had completed a training needs analysis and were developing a formal training package.

- Staff received monthly managerial and clinical supervision and yearly appraisal. Trust data showed an annual appraisal rate of 92% and the supervision rate was 87.9% from the period between 1 October 2017 and 31 October 2017.
- Monthly team meetings took place for staff to share information.

Multi-disciplinary and inter-agency team work

- Staff held weekly medical reviews. Additionally, multidisciplinary team meetings took place where staff discussed community patients, inpatients, and new referrals.
- Staff discussed patients' needs such as patients' food and drink intake, risks and challenging behaviours at handover meetings. Managers attended these meetings.
- Staff had effective joint working with other teams in the organisation. Some staff such as an occupational therapist worked also in the community teams and this was useful for communication. Some community staff were based at the same location as the ward.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff treating patients with kindness dignity and respect.
- Patients gave examples of how staff helped them, for example with their physical health needs and managing daily living skills such as cooking, cleaning and laundry.
- A carer told us they were concerned that their relative had put on an excessive amount of weight since being admitted to the ward. Staff told us that they encouraged patients to make healthy lifestyle choices but respected patients' rights to make unwise choices where they had capacity to do so. In this case, the patient had capacity.

The involvement of people in the care they receive

- There was an easy read information leaflet that patients were given on admission to the ward, and staff ensured that patients were orientated to the ward environment.
- Care records demonstrated that patients had been involved in their care plans and patients confirmed this.
- Carers said they were invited to attend multidisciplinary meetings, we observed that staff asked them for their views on the care.
- Staff, carers and patients said patients were offered easy read versions of their care plans.
- Patients had access to independent advocates.
- Patients gave feedback on the service at 'patient forum' meetings and morning meetings such giving their views and making choices about daily activities, individual time with staff and menus.
- Patients were involved in staff recruitment in the 12 months prior to inspection.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- For the last six months, the average bed occupancy was 83%. The average length of stay for patients was approximately three to six months; this was as would be expected.
- Prior to a patient's admission a telephone conference call was held with the multidisciplinary team, the commissioner and social care staff, to ensure admissions were appropriate to patient need.
- The ward provided a service for South Essex, Southend and Thurrock. In addition to seven commissioned beds, five were available for spot purchase by commissioners.
- If a patient needed a higher level of care then a psychiatric intensive care unit could be accessed locally, although we observed that it was difficult to get a bed at this unit during inspection.
- The ward admitted patients from age 18 to 65 years of age. An older person had been admitted to the ward due to there being a lack of beds in other services, but this was unusual.
- Managers provided commissioners with weekly reports with updates on patients, we also observed commissioners attended a ward round meeting. Discharge plans were discussed at weekly reviews. Carers gave examples of being involved in discharge planning.
- The service worked closely with the intensive support team for learning disability and mental health who provided community support as an alternative to admission in the unit and supported patients on leave from the ward.
- When patients went on leave, their bed remained available should they need to return from leave earlier than planned.
- At the time of inspection, there was one delayed discharge due to a patient not having suitable move on accommodation. Commissioners and social care staff external to the team were working to resolve this.
- Care plans referred to section 117 aftercare services for patients who had been detained under section 3 or equivalent powers of the Mental Health Act (1983).

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a range of rooms to support treatment and care such as an activity room and an activities kitchen (separate from the main kitchen).
- The ward had an identified room for visitors outside the patients' main living space. Carers could visit their relative's bedrooms, on an individually risk assessed basis.
- Patients had access to outside space and gardens. A patient told us they were going on leave that day into the community for a shopping trip. Staff said they would take patients to local community groups and activities such as cycling.
- The ward had a chef. Patients gave examples of being able to have favourite foods. Access to the area for patients to have drinks and make snacks was restricted due to the risk patients posed. Patients could access the activities kitchen to make breakfast under supervision of staff.
- Patients personalised their bedrooms. However, two patients told us their preference was to have a minimalist bedroom with minimal furniture and items and this was reflected in their care plan.
- Staff did not encourage patients to bring all their possessions with them on admission, as there were not identified areas for storing possession securely in rooms. Two patients did not have direct access to a wardrobe or clothing in their room due to risks they might have with furniture. Managers had submitted a bid for new purpose built furnishings which they had sent to the task and finish group to be considered at the next meeting in November 2017.
- At our last inspection five patients' bedrooms did not have curtains due to risks or patients' choice and did not have privacy film which meant their dignity was not protected. This had been resolved and the privacy film was being installed on bedroom windows on the day we inspected.

Meeting the needs of all people who use the service

Are services responsive to people's needs?

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

- Patients had individualised activity programmes based on their assessed level of need.
- There were suitable adjustments for people requiring disabled access including an assisted bathroom and bedroom.
- Information leaflets were available in other languages for patients for whom English was not their first language. Information was also available in easy read format. This included information about treatments, patient's rights and how to complain.
- There was a designated chef on the ward and patients had a choice of food to meet their dietary requirements and could make individual requests.
- Staff supported patients to access appropriate spiritual support in the local community.

Listening to and learning from concerns and complaints

- Managers told us they had received two complaints from neighbours about the noise during the summer and they had resolved these locally. One carer had complained about not receiving timely information about their relative again managers told us this complaint was resolved locally.
- Patients knew how to complain and told us they would be supported by advocates if necessary.
- Staff told us they knew how to handle complaints we saw evidence on the team meeting standing agenda that complaints and learning from incidents was a standing agenda item.

Are 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.

Our findings

Good governance

- Although the trust governance processes identified issues, the trust did not always take action in a timely manner.
- At our last inspection, we had concerns about the length of time the trust had taken to address risks identified for this ward. This included the effectiveness of trust governance systems to ensure action was taken to respond to highlighted risks and give feedback to staff when they had raised concerns. At this inspection, we saw that managers had appointed a task and finish group to meet monthly and ensure that issues were addressed. At ward level, the manager had ensured the housekeeper had protected time every week to review the list of tasks for completion and chase them up with the maintenance department. Some works had been completed but there continued to be a considerable delay. Managers had revised the ligature risk assessment, and potential risks were now identified using photographs. Measures such as staff observation of patients in areas where risks remained were recorded as mitigation.
- At the time of our visit, managers had completed plans for a business case to present to the board, for developing a de-escalation suite and trust investment in the ward.
- A senior manager had completed a nursing establishment review report in July 2017 with a bid to request additional staffing. The ward environment and current staffing levels had been highlighted as issues on the trust risk register. Information on staffing was due to be submitted to the board of directors meeting on 29 November 2017. Whilst managers were aware of national guidance for patients to have positive behavioural support plans and had begun to train staff in this model of care planning, they had not achieved their target of training all staff by October 2017. Consequently, not all patients had positive behavioural support care plans.
- Managers did not have sight of any targets to monitor the performance of the team.

Leadership, morale and staff engagement

- Managers and staff told us they did not always debrief staff after incidents.
- Senior managers had not recruited to the deputy ward manager vacancy.
- Staff felt senior trust managers did not have a good understanding of the problems faced by staff. In particular, patient's needs had increased over recent months. There was not sufficient staff to take patients out for leave, or to enable staff to get breaks.
- Staff reported being passionate about their work and committed to delivering a good service for patients and said the morale was generally good. Staff said they had felt frustrated at times due to low staffing levels.
- Staff said there was good team working and they felt supported by their manager. They said they knew how to use the whistle-blowing process and raise concerns without fear of victimisation. Most said they felt able to give feedback on the service. Managers said they have an 'open door' for staff to approach them with any concerns.
- The ward manager was new in post; they had opportunities for leadership training. However, due to staffing needs they were required to be on the ward and were not able to give the time they wanted to management tasks.
- Trust data showed that staff turnover was 7.6% with two staff leaving between 1 November 2016 and 31 October 2017.
- Managers had systems to monitor staff performance and sickness. For the months of September 2017 and October 2017 staff sickness was 19.8% and 25.8% respectively against a target of 4.5%. Managers told us there were two staff on long term sick which accounts for this high percentage against a small staff team.

Commitment to quality improvement and innovation

- The trust was a member of the 'Quality Network for Inpatient Learning Disability Services' and Byron Court was accredited up to April 2018 given an 'excellent' rating

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Not all maintenance issues identified at the last report had been addressed. • Not all patients had suitable furnishings to house their belongings and promote their recovery. • The trust had not ensured that all patients had positive behavioural support plans to prevent the need for restrictive practices. This was a breach of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The fridge in the activities of daily living kitchen recorded temperatures above the recommended range. We were not assured that food was stored safely in this kitchen. This was a breach of regulation 15

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 • Managers did not have sight of performance targets for their ward. • Managers did not ensure that staff were debriefed after incidents. This was a breach of regulation 17

This section is primarily information for the provider

Requirement notices

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 • The trust had not ensured adequate staffing of shifts on wards. This was a breach of regulation 18